STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E630	A. BUILDING _____ B. WING _____	08/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANTHONY COMMUNITY CARE CENTER	212 N 5TH AVE ANTHONY, KS 67003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the health resurvey and complaint investigations into #66011 and #67882.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 156	Continued From page 1 The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use	F 156		

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F 156	Continued From page 2 Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This Requirement is not met as evidenced by: The facility census totaled 25 residents. Based on observation, interview and record review, the facility failed to furnish a written posting of contact information for the State ombudsman (resident advocate) program. This had to potential to affect all 25 residents who resided in the facility. Findings included. - Observation on 8/12/13 at 11:07 A.M. and confirmation by Licensed Nursing staff L revealed no ombudsman information posted and available to residents in the facility. During an interview at 3:26 p.m. on 8/13/13 with a resident who frequently attended resident council meetings revealed he/she knew of information posted on a bulletin board about the ombudsman, but reported staff did not talk about the ombudsman, and the resident did not know what that term meant. Interview with activities staff I on 8/13/13 at 5:27 p.m. revealed Staff I had not talked with residents in resident council recently about the ombudsman, and reported he/she thought it had been about 3 months since last talking about the ombudsman. Review of the facility resident council meeting minutes revealed the most recent meeting in which the ombudsman was discussed was 1/27/12.	F 156		

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F 156	Continued From page 3 Interview with administrative nursing staff A on 8/15/13 at 5:15 p.m. revealed he/she did not recall if the ombudsman information had been posted during initial tour. Staff A reported the wall where the ombudsman information currently hung had recently been painted, so staff had taken some of the postings down. The facility failed to provide a policy regarding Ombudsman postings. The facility failed to ensure the availability of written contact information for the State ombudsman program.	F 156		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		

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F 225	Continued From page 4 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This Requirement is not met as evidenced by: The facility census totaled 25 with 18 resident's included in the sample. Based on observation, interview, and record review, the facility failed to ensure alleged allegations of abuse involving mistreatment of a resident by another resident, were investigated, for 1 of 3 sampled residents. (#13) Findings included: - Review of the resident #13's annual MDS (minimum data set) dated 1/9/13 revealed a BIMS (brief interview for mental status) with a score of 15 (cognitively intact). It identified the resident displayed rejection of care behaviors 1 to 3 days of the 7 day look back period. It identified the resident required total dependence of 2 people for bed mobility, transferring, dressing, toilet use, and personal hygiene. Review of the resident's quarterly MDS dated 7/4/13 revealed it identified the resident had a BIMS with a score of 15 (cognitively intact). It identified the resident had displayed rejection of	F 225		

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F 225	Continued From page 5	F 225		

care behaviors for 1 to 3 days of the 7 day look back period. It also identified the resident needed extensive assistance of two people for bed mobility, transferring, dressing, toilet use, and personal hygiene.

Review of the resident's Cognitive Loss/Dementia CAA (care area assessment) revealed the resident's cognitive function and memory was intact as evidenced by a BIMS assessment score of 15.

Review of the care plan with a date of 9/17/12 revealed the resident had manipulative personality secondary to long term care living and impulsive and attention seeking behaviors. It directed the staff to be assertive and non-judgmental when the resident was rude or hurtful toward the staff, and reassure him/her that his/her rights are still being upheld, provide the resident with alternative ways to approach the disagreeable situation so it would not happen again. It identified the resident often became upset if he/she feels he/she didn't get something he/she wanted. When this happened, the resident had increased behaviors, manipulation and began to tell lies about staff. It directed staff to address the resident with two staff members, one for a witness, and to notify the charge nurse or DON (director of nursing) if behaviors occurred. It also identified the resident frequently put staff member on different shifts against each other and directed staff to discourage this behavior and report occurrences to the charge nurse or DON.

On 8/12/13 at 1:44 p.m. observation revealed the staff came out of the resident's room after changing him/her. The resident was laying on his/her bed with covers on and watching

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F 225	Continued From page 6 television. On 8/13/13 at 8:35 a.m. observation revealed the resident interacted with the staff as they went in to his/her room to give him/her medication. On 8/12/13 at 1:34 p.m. an interview with the resident revealed another resident (#23) came into his/her room in the middle of the night last week and yelled at him/her about stealing his/her car, then proceeded to hit and spit on the resident. The resident stated he/she reported the encounter to the DON (director of nursing) the morning after it happened, the DON told the resident they were trying to handle the situation but wouldn't tell the resident any more about the situation. The resident also reported the DON had not let the resident know, to date, what was being done about the situation. On 8/12/13 at 3:08 p.m. an interview with the resident reported she does not feel safe around resident #23. The resident reported it bothers him/her to see resident (#23) in the hallway. The resident also reported when in the dining room he/she feels ok until he/she sees resident #23 coming toward him/her and then he/she became nervous because he/she didn't know what to expect from resident #23. On 8/12/13 at 4:09 p.m. an interview with administrative staff A revealed he/she had heard about the encounter between resident's #23 and #13. Staff A confirmed the allegation was not reported to the state or investigated further. When asked about an investigation report, staff A was unable to produce an investigation report. On 8/13/13 at 3:35 p.m. an interview with direct care staff G reported he/she had not heard of any	F 225		

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F 225	Continued From page 7 incidents between resident #23 and this resident. Staff G confirmed that if a resident told her another resident abused them, he/she would report it to the DON. On 8/14/13 at 11:27 a.m. an interview with licensed staff K revealed he/she expected the aides to report any kind of abuse, physical, sexual, or verbal abuse to him/her. Staff K reported if he/she learned of resident to resident abuse, he/she would have separated the two residents, charted the information as a behavior, and informed the DON or administrator. Staff K reported he/she knew of an incident between resident #23 and resident #13 but did not know of any details and stated he/she would have filled out an incident report if he/she had been told of this type of incident and he/she would have reported it to the DON, and charted it as a behavior for that resident. On 8/14/13 at 3:00 p.m. an interview with administrative staff A, confirmed he/she should have investigated the allegation further. On 8/15/13 at 5:35 p.m. an interview with administrative staff A reported he/she was aware of resident #23 going into resident #13's room and yelling at him/her. Staff A confirmed the allegation should have been investigated further. The facility failed to ensure that alleged violations of abuse, including resident to resident abuse, were investigated, in order to prevent further potential abuse.	F 225		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or	F 242		

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F 242	Continued From page 8 her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This Requirement is not met as evidenced by: The facility census totaled 25 residents with 18 included in the sample. Three residents were reviewed for choices. Based on observations, interview and record review, the facility failed to ensure 1 of 3 sampled residents could make choices about his/her bathing schedule. (#25) Findings included: - Resident #25 had an Annual Minimum Data Set (MDS) dated 6/13/13, the resident scored an 11 for Brief Interview for Mental Status (BIMS-indicative of moderately impaired cognition). The assessment showed it was very important to the resident to choose what clothes to wear, to take care of personal belongings, choose bedtime, have family or close friend involved in discussions about care, and somewhat important to choose between tub bath, shower, bed bath, or sponge bath. The MDS also identified the resident needed extensive assist of one for bed mobility and transfers, walking in room and corridor, locomotion off unit, dressing, toilet use, and limited assistance of one for personal hygiene. Review of the resident's care plan with an initiated date of 6/18/13 and next review date of 9/19/13 revealed the resident was totally dependent on staff to provide a bath twice a week and as necessary. The care plan lacked the type of bath preference or the time of day.	F 242		

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F 242	Continued From page 9 Review of the resident bath flow sheet revealed resident received a showers on Tuesdays and Thursdays the week of Aug 4th, on Tuesday and Friday the week of July 28th, on Tuesday and Thursday the week of July 21st, on Tuesday and Friday week of July 14th, and on Tuesday week of July 7th (refused the Friday shower),on Tuesday and Thursday week of June 30th. Observation at 1:45 P.M. on 8/12/13 revealed the resident sat in a recliner in his/her room. During an interview with the resident at 10:00 A.M. on 8/15/13, reported he/she took a bath when he he/she lived at home, and also took one when he/she lived in the apartment prior to coming to live here. He/she said he/she did not remember if he/she ever got asked about if he/she wanted a bath or shower, and also reported they did not ask him/her before each bath or shower about what kind he/she wanted that day. He/she said he/she would like a bath, and liked baths better than showers. At 1:51 P.M. on 8/12/13 Direct care staff Q reported they had a bath aide who came in and gave baths on Tuesday and Friday mornings and someone gave baths on Monday and Thursday evenings. On Wednesdays they picked up any others that were needed. They did not have any baths on Saturday and Sunday. During an interview at 8:10 A.M. on 8/13/13, Direct care staff D said she/he would take the resident to the restroom and then to the shower. Observation at that time revealed he/she applied a gait belt to the resident and staff assisted the resident to his/her wheelchair and then took the resident to the restroom. She/he also reported	F 242		

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F 242	Continued From page 10 they would give today till around noon then she/he would help on the floor the rest of the day. She/he also stated If a resident wanted a shower 5 days a week they can get it. We have one resident who does. They usually have enough time to get all the baths done. Interview with Administrative Nurse B at 1:07 P.M.at 8/14/13 revealed the bath aide goes in and talks to them about the type of bath /shower and the time of day. Activities staff ask about preferences, but not he/she was not sure if bathing is on that preference form. Direct care staff I, on 8/14/13 at 1:14 PM reported they ask each time if the resident wants to take a bath or shower. Interview with Administrative nurse A on 3:49 PM at 8/15/13 thought Administrative Nurse B sets those schedules up with the aides. Staff should talk with the resident about type of bathing they want and said it should be on their care plan. The facility failed to honor the resident choice of having baths instead of showers.	F 242		
F 243 SS=E	483.15(c)(1)-(5) RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP A resident has the right to organize and participate in resident groups in the facility; a resident's family has the right to meet in the facility with the families of other residents in the facility; the facility must provide a resident or family group, if one exists, with private space; staff or visitors may attend meetings at the group's invitation; and the facility must provide a designated staff person responsible for providing assistance and responding to written requests	F 243		

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that result from group meetings.

This Requirement is not met as evidenced by:
The facility census totaled 25 residents. Between 6 and 12 residents attended resident council each month. Based on interview and record review, the facility failed to provide a private space for the resident council to meet, and failed to ensure staff received an invitation from the resident council group prior to staff attending. This had the potential to affect all residents who attended the resident council meetings.

Findings included:

- During an interview with a resident who frequently attended resident council at 3:26 p.m. on 8/13/13, the resident reported he/she did not think the resident council members could meet privately without staff if the resident council wanted. The resident reported it has always been that staff members attended, and did not think it would be okay to meet privately.

During an interview on 8/14/13 at 1:10 p.m. with activities staff I revealed he/she usually went and got Social services staff S to come to the resident council meetings. Both the social services staff S and staff I attended the meetings regularly. "Since I am kind of new to this, the [social services staff S] helped me out." Staff I reported that he/she invited other staff members to attend if they were new, and it is posted on the activity schedule and staff members came if they wanted. Staff I confirmed the residents did not invite them. Staff I reported he/she thought it would be okay for the residents to meet privately, but reported he/she did not think the residents had the capability to do so. Staff I reported he/she did not think he/she

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F 243	Continued From page 12 ever let the residents know they could meet without staff present. A policy was requested on 8/19/13, but none was provided regarding privacy of residents at resident council meetings. The facility failed to provide a private space for those who attended resident council meetings, and failed to ensure staff only attended after receiving an invitation from the residents.	F 243		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This Requirement is not met as evidenced by: The facility census totaled 25 residents. Between 6 and 12 residents attended resident council each month. Based on interview and record review, the facility failed to act upon grievances and recommendations brought up in resident council, and failed to communicate its decisions back to the resident council regarding the recommendations. This had the potential to affect all 6-12 residents who attended the resident council meetings. Findings included: - Review of the resident council meeting minutes revealed: Review of the minutes for the resident council meeting on 1/24/13 revealed 7 residents attended	F 244		

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the meeting. It identified residents had concerns about being left in the dining room, maintenance took "a while to come and fix problems " , residents wanted more weekend activities, and included a long list of food the residents wanted to see served.

No meeting minutes available for February, 2013

Review of the 3/21/13 minutes revealed 12 residents attended. Residents had concerns about maintenance not hanging pictures, a resident had been "told [gender] uses call light too much", missing socks, residents wanted Sunday Bingo and more card games, and included a long list of food the residents wanted to see served.

The 4/25/13 resident council notes revealed 8 residents attended the meeting. Residents had concerns about a list of foods that the residents wanted to see served, laundry mix-ups with the residents receiving the wrong clothes.

Review of the 5/31/13 minutes revealed 12 residents attended the meeting. Minutes revealed residents again had concerns about maintenance not hanging pictures, "Residents say it takes it takes a long time to be served and when everyone leaves they can't get more coffee or things. Hard to get someone to serve them", and again a list of foods the residents wanted to see served.

Review of the 6/27/13 minutes revealed 6 residents attended. Residents had concerns about missing socks, wanted more variety from dietary, and activities not getting done when activities staff was not in the facility.

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Review of the 7/26/13 minutes revealed 8 residents attended the meeting. The residents had concerns about missing clothing from laundry, nursing a little slow answering call lights, and residents still felt they didn ' t have enough help.

During an interview with a resident who frequently attended resident council at 3:26 p.m. on 8/13/13, he/she confirmed residents suggested new food items for the menus, but reported he/she did not know of staff adding any of those item to the menus or why they did not add them. The resident also reported he/she still had concerns with staffing, and call lights being left on for long periods of time before staff could answer them. The resident reported he/she thought staff went around and talked with residents individually about follow up related to concerns. The resident confirmed the resident council had multiple repeated concerns.

Interview with activities staff I on 8/13/13 at 5:27 p.m. revealed for nursing staffing, staff I talked with the residents a lot one on one, and talked with Administrative Nursing staff A about it/ Staff I reported with the census being down, less staff worked each shift. Staff I also reported he/she thought staff received education regarding call light times after printing off call log reports. Staff I confirmed he/she needed to make residents aware of how staff addressed the problems.

Review of the facility ' s Grievances/Complaints policy dated 2/7/2001 revealed it identified, " 1. RIGHT TO COMPLAIN OR FILE A GRIEVANCE: It is the right of all Residents, resident ' s representatives, families of Residents, Responsible Parties and Legal Guardians to: A.

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F 244	Continued From page 15 Register complaints to the Administrator or any Department Head of the Facility. B. Know what action has been or willing be taken;.. " The facility failed to act upon grievances and recommendations brought up in resident council, and failed to communicate its decisions back to the resident council regarding the recommendations.	F 244		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care	F 272		

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F 272	Continued From page 16 areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This Requirement is not met as evidenced by: The facility census totaled 25 residents with 18 included in the sample. The sample included the review of comprehensive assessments for all 18 residents. Based on interview and record review, the facility failed to have a system to ensure the accurate completion of the CAAs (Care Area Assessments) for care areas identified on the MDS (Minimum Data Set) that required a further assessment) for 9 of the 18 sampled residents. (#30, #11, #31, #1, #34, #8, #25, #27, and #26) Findings included - Review of the Annual MDS' for residents #30, #11, #1, #8 #27 and #25 revealed the assessments identified the need for further assessments in Psychotropic Medication Use, Cognitive Loss/Dementia, ADL (Activities of Daily Living) Function/Rehabilitation, and Dental. Review of the corresponding CAAs for the further assessments revealed staff left them blank, or included a one line that identified the problem, such as "The resident has dementia" or "the resident's dentures are loose." The CAAs lacked an analysis of the resident's strengths, weaknesses or findings to help develop an individualized plan of care for the residents. Review of the Admission MDS's for residents	F 272		

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F 272	Continued From page 17 #31, #34, and #26 revealed the MDS' identified the need for further assessments (CAAs) for ADL Function/Rehabilitation, Cognitive Loss/Dementia, Psychotropic Medication Use, Falls, Behaviors, Nutrition, and Dental. Review of the corresponding CAAs for the further assessments revealed staff left them blank, or included a one line that identified the problem. The CAAs lacked an analysis of the resident's strengths, weaknesses or findings to help develop an individualized plan of care for the residents. Interview with administrative nursing staff B on 8/15/13 at 12:16 p.m. revealed the CAA was intended to help determine the need existed to care plan a particular area and what should be documented to know what things contributed to certain problems for individual residents. Staff B reported when he/she did the care plans, he/she did not necessarily go back and include everything from the CAA. Interview with administrative nursing staff A on 8/15/13 at 5:15 p.m. revealed the purpose of the CAA was to assess that area of care and look at the different problems that caused the areas to trigger. Staff A reported you had to look at the total person in each area of care to see what the problems were in that area and then developed the care plan to try to improve or maintain those areas. The facility failed to provide an MDS or CAA policy. The facility failed to have a system to ensure the comprehensive assessements included the completion of the CAA, to help make the plan of care individualized for each resident.	F 272		

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F 279 SS=E	Continued From page 18 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This Requirement is not met as evidenced by: The facility census totaled 25 residents with 18 included in the sample. Based on interview and record review, the facility failed to plan the needs of 4 of 18 sampled residents in regard to nutrition, skin conditions not pressure related, urinary incontinence, and ADL (Activities of Daily Living) needs for dental hygiene. (#26, #34, #8, #33) Findings included: - Review of the Admission MDS (Minimum Data Set) for resident #34, revealed the resident had a BIMS (Brief Interview for Mental Status) score of 2, indicating the resident had severe cognitive	F 279 F 279		

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impairment. The assessment identified the resident as independent with set up help with bed mobility, toileting, required supervision and one person limited assistance with personal hgyiene, was not on a toileting program and was continent of urine at all times.

Review of the quarterly MDS dated 8/2/13 revealed the resident had moderately impaired decision making, and required extensive assistance from one staff with bed mobility, toilet use, personal hygiene, experienced frequent urinary incontinence, and staff placed the resident on a toileting program.

Review of the resident's care plan for ADL assistance with a revision date of 5/29/13 revealed it lacked anything indicating the resident had incontinent episodes or required assistance with toileting.

Interview with administrative nursing staff A on 8/15/13 at 5:15 p.m. revealed at the care plan meetings, each department head attended and each team member shared information about the resident to develop better care plans. Nurse A stated he/she would expect the care plan to include how much assistance the resident required with toileting, when to toilet, toileting every 2 hours, voiding pattern. Staff A stated he/she was not sure what kinds of assessments are done during admission, but a continence assessment would be helpful to include when the resident voided, how frequently, and how much assistance the resident needed.

Review of the facility's policy on Comprehensive Care Plans, dated 2/1/05, identified the facility will develop a comprehensive care plan for each resident that included measurable objectives and

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timetable to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The facility failed to develop a comprehensive care plan that addressed the toileting needs for a resident that experienced urinary incontinence.

- Review of resident #8's annual MDS (Minimum Data Set-a required assessment) dated 10/31/12 revealed it identified the resident with a BIMS (Brief Interview for Mental Status) score of 15 (indicative of little to no cognitive impairment). The assessmnet identified the resident required supervision and set-up assistance with eating, had no swallowing problems, a steady weight of 142 pounds, and did not receive a therapeutic or mechanically altered diet.

Review of the resident's quarterly MDS assessment dated 8/2/13 revealed it identified the resident with a BIMS of 15, needed supervision and set up assistance with eating, had no loss of liquids or solids from mouth when eating or drinking, holding food in mouth, couging or choking, or complaints of difficulty or pain when swallowing. It identified the resident had experienced a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months, a weight of 125 pounds, and did not receive a therapeutic or mechanically altered diet.

Review of the care plan revealed it lacked anything regarding weight loss. Review of the resident's Care Plan Conference Sumary dated 2/5/13 identified staff documented "the resident came to dining room for meals- appetite good."

Interview with administrative nursing staff A on 8/15/13 at 3:49 p.m. revealed at the care plan

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meetings, each department head attended and each team member shared information about the resident to develop better care plans. Nurse A stated he/she would expect the care plan to include information regarding the resident's weight loss, what interventions had been developed, and what did not work, so that they could develop new interventions.

Review of the facility's policy on Comprehensive Care Plans, dated 2/1/05, identified the facility will develop a comprehensive care plan for each resident that included measurable objectives and timetable to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The facility failed to develop a care plan that addressed a resident's weight loss.

- Review of resident #26's Admission MDS (Minimum Data Set) dated 4/26/13 revealed it identified the resident with a BIMS of 3 (indicated severely impaired cognition) and required the limited assistance of 1 for bed mobility, transfers, walking in room, supervision of one for walking in corridor, no open lesions, surgical wounds, burns, skin tears or MASD (Moisture Associated Skin Damage).

Review of the resident's Quarterly MDS assessment dated 7/27/13 revealed it identified the resident with a BIMS of 6 (severely impaired cognition), required extensive assistance from one staff with bed mobility, transfers, toileting and at risk for the development of pressure ulcers.

Review of the Pressure Ulcer CAA (Care Area Assessment) for the 4/26/13 MDS revealed resident is less mobile and requires walker to

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ambulate...Family aware of increased risk... Care plan will focus on prevention. Keeping resident clean and dry. ADL (Activities of Daily Living) CAA did not trigger for futher assessment.

The current care plan identifeid the resident required 1 staff participation with personal hygiene and oral care, and did not address anything else regarding skin.

Interview with administrative nursing staff A on 8/15/13 at 3:49 p.m. revealed at the care plan meetings, each department head attended and each team member shared information about the resident to develop better care plans. Nurse A stated he/she would expect the care plan to include information regarding the facilities interventions to prevent the development of pressure ulcers.

The facility failed to develop a care plan that included interventions to help prevent the develop of pressure ulcers for a resident at risk for the development of pressure ulcers.

- Review of resident #33's Admission MDS (Minimum Data Set) dated 4/26/13 revealed a BIMS (Brief Interview for Mental Status) score of 12 (indicated moderately impaired cognition), required the extensive assistance of one staff for bed mobility, transfers, dressing, toilet use, and dependent on staff for personal hygiene. Review of the ADL (Activities of Daily Living) Functional/Rehabilitation Potential CAA (Care Area Assessment) for 4/26/13 MDS identified the resident required extensive assist with all ADLs, and " must have walker and one assist " to ambulate. The assessment also identified the resident and/or Family " would like resident to ambulate in hallway daily " . "Care plan will focus

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F 279	Continued From page 23 on maintaining and minimizing decline. Also to minimize risks such as skin issues and continence issues. " The record revealed it lacked a care plan for the resident. The facility failed to develop a care plan that identified the ADL needs for this resident that required staff assistance.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: The facility census totaled 25 with 18 resident's included in the sample. Based on observation, interview, and record review, the facility failed to revise comprehensive care plans to include the	F 280		

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current care needs for 5 of 18 sampled residents for dental concerns, pressure ulcers, skin conditions, and accidents relating to falls. (#25, #23, #10, and #31)

Findings included:

- Review of resident # 23's significant change MDS (minimum data set) dated 10/24/12 identified the resident had a BIMS (brief interview for mental status) with a score of 00 (severe impairment). It identified the resident had rejection of care behaviors for 4 to 6 days. It identified the resident needed extensive assistance of one person for bed mobility, transferring, dressing, and toilet use and the resident needed limited assistance of one person for eating and personal hygiene. It identified the resident had no obvious or likely cavity or broken natural teeth and no mouth or facial pain, discomfort or difficulty with chewing.

Review of the resident's quarterly MDS dated 7/12/13 revealed a BIMS with a score of 99 (unable to complete the interview). It identified the resident had short and long term memory problems. It also identified the resident had no rejection of care behaviors exhibited. It identified the resident needed limited assistance of one person for bed mobility, needed supervision of one person for transferring, and extensive assistance of one person for dressing, eating, toilet use, and personal hygiene. It also identified the resident had no mouth or facial pain, discomfort, or difficulty with chewing.

Review of the Cognitive Loss/Dementia CAA (care area assessment) dated 10/24/12 revealed no analysis of findings documented. The Dental Care CAA did not trigger for this resident.

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F 280	Continued From page 25 Review of the resident's care plan with a date of 5/1/13 revealed the resident had a self care deficit related to progressive dementia (a progressive mental disorder characterized by failing memory and/or confusion). It identified the resident required limited assistance with brushing teeth every morning and every night and directed the staff to set up his/her moistened toothbrush with toothpaste and guide his/her hand if he/she will allow and if not, staff are to attempt to brush his/her teeth. The care plan failed to identify the resident's current dental status including the resident's chipped left front tooth. Review of the resident's "oral interview" regarding her oral status, asked if the resident had any obvious or likely cavity or broken natural teeth and the answer filled in is "no". Review of a fax provided to the facility by the resident's dentist office dated 12/20/12, revealed the resident's chipped tooth was not addressed in the dental visit. Review of the resident's chart revealed no documentation recorded that the resident's family was notified of the resident's broken tooth. The facility failed to provide any documentation regarding the resident' chipped front tooth, or any documentation that the resident's family was notified. On 8/12/13 at 2:40 p.m. observation of the resident revealed the resident sitting in the entryway talking with staff. The resident's front tooth (left) is chipped. On 8/13/13 at 1:11 p.m. an interview with direct care staff E revealed he/she would report to the	F 280		

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nurse if a resident's gums were bleeding, had sore dentures, their dentures didn't fit correctly, or if the resident had chipped teeth. Staff E reported he/she didn't know if the resident had any problems with his/her teeth and reported he/she did not know the resident had a chipped tooth.

On 8/13/13 at 1:15 p.m. an interview with direct care staff C revealed he/she would let the nurse know about blisters on a resident's gums, bleeding gums, discoloration, loose teeth, broken dentures, chipped or broken teeth. Staff C stated he/she did not think the resident had any problems with his/her teeth and did not notice he/she had a chipped front tooth.

On 8/13/13 at 1:45 p.m. an interview with administrative staff B revealed he/she fills out an "oral interview" form for the residents. Staff B reported another staff member looks in the resident's mouths, fills out some other form, gives it to staff B and staff B then is able to fill out the "oral interview" form from that information.

On 8/13/13 at 1:55 p.m. an interview with licensed staff L, revealed he/she would expect the CNA's to report bleeding gums, foul smelling mouth, discoloration of gums, chipped teeth, missing teeth, dentures that did not fit correctly, if a resident was not eating because of their dentures not fitting correctly, and discoloration of natural teeth. Staff L reported after the aides notified her, he/she looked at the resident's teeth and would then call the resident's dentist. Staff L confirmed at that time, by looking in the resident's mouth, the resident had a chip in his/her left front tooth. Staff L confirmed the chip would be something he/she would have called the dentist about and he/she also confirmed he/she had not called the dentist about the chip in the resident's left front

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F 280	Continued From page 27 tooth. On 8/14/13 at 10:39 a.m. an interview with administrative staff A reported his/her expectation is for the nurse aides to report any dental issues to the charge nurses, the charge nurses are to document the issues in the nurses notes and the charge nurses are to call the dentist and make an appointment or arrangements for the issues to be addressed. Staff A also confirmed any dental issues should be documented on the MDS. Staff A confirmed the aides should report to the charge nurse, any chipped teeth a resident had. Review of the facility policy for Dental Services, with a date of 2/1/05, revealed "Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care". The facility failed to revise and update the care plan to reflect resident #23's current dental status by failing to address the resident's chipped left front tooth. - Review of resident #10's annual MDS (Minimum Data Set) dated 11/28/12 revealed a BIMS (Brief Interview for Mental Status) score of 8, indicating moderate cognitive impairment, did not exhibit behaviors of rejecting care. The assessment identified the resident required extensive assistance from one staff for bed mobility, independent when walking in the room/corridor, toileting, and required supervision with set up assistance from staff with personal hygiene, eating, was not at risk for the development of pressure ulcers and did not have any pressure ulcers. Review of a quarterly MDS dated 5/30/13	F 280		

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revealed a BIMS score of 5, (indicating severe cognitive impairment), did not exhibit behaviors including rejection of care. The resident required supervision with set up assistance from staff with bed mobility, walking in the room/corridor, independent with transfers, and required supervision from one staff with toileting, and one person limited assistance with personal hygiene. The assessment identified the resident at risk for the development of pressure ulcers, had two stage 2 pressure ulcers (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough), received pressure ulcer care, was on a on a turning/repositioning program, and staff used a pressure relieving device on the chair and in bed.

Review of the CAAs (Care Area Assessments) for Pressure Ulcers, ADL (Activities of Daily Living), and Nutritional Status CAAs dated 11/28/12 revealed staff failed to complete an analysis of findings. .

Review of the resident's pressure ulcer care plan, located in a chart at the nurse's station and revised by staff on 3/5/13 revealed the resident had an entered the facility (on 12/8/11) with a stage I and stage II on each buttock and the resident had an increased risk for more pressure ulcers due to a diagnosis of dementia, a history of pressure ulcers, medications, and the resident's choice to sleep in his/her recliner as he/she had done for the past 40 years. Interventions directed staff to complete a wound assessment and document the assessment at least every 7 days, notify the physician if no improvement in 2 weeks or if staff noted worsening in the wound at any time, provide Resource Breeze (a dietary supplement) three times a day. It also directed staff to conduct skin inspections with showers,

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Braden scale (assessment for risk of development of pressure ulcers) every 3 months and PRN (as needed), follow nutritional interventions, and encourage the use of pillows under one hip to offload buttocks slightly (changing every 1/2-1 hour) from 7 a.m.-1 a.m. daily. The resident slept in a recliner, encourage and supervise the resident to stand up for 5 minutes every 1/2-1 hour from 7 a.m. until 1 a.m., and give vitamin C, Zinc, and multivitamin and healthy shots (dietary supplements) ordered twice a day. On 6/13/12, staff added an intervention that identified the treatment of Xeroform (type of medication soaked in gauze), bandage powder (type of medicated powder), and Opsite (clear dressing) to left buttock's open area daily and PRN. Staff marked the area as resolved, but failed to date the entry onto the care plan. Staff changed the time for repositioning from every 1 and 1/2 hours to every 1/2-1 hour on 6/19/12. No further interventions had been added after 6/19/12.

Review of the resident's computerized pressure ulcer care plan, dated 3/13/13, revealed the resident had a Stage 2 pressure ulcer on the right inner buttock related to a history of pressure ulcers, choosing to sleep in his/her recliner rather than bed, his/her scooting down/sliding down in his/her recliner, and refusal to change position even with staff offering assistance. The interventions for staff included administer treatments as ordered and monitor for effectiveness, assess/record/monitor wound healing weekly. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD (physician). The resident needed reminding and assistance with (or he/she will say

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ok and not change positions) to turn/reposition at least every 2 hours, more often as needed or requested. Monitor/document/report to MD PRN changes in skin status: appearance, color, wound healing, s/sx (signs/symptoms) of infection, wound size (length X width X depth), stage. Pressure relieving roho (brand of cushion) air cushion in his/her recliner at all times. The resident preferred to sleep in his/her recliner. He/she refused to sleep in his/her bed. Attempt to encourage and offer assistance with getting into bed if willing at least for a short period of time. Try alternative methods to gain compliance with position changes and sleeping in bed.

Review of the computerized documentation revealed that on 4/25/13, staff documented the resident was "Noted to have a new open area to left buttocks near coccyx. Resident has order for Lantiseptic (Skin Protectant with a high-lanolin formula) ointment twice a day and PRN (as needed). Will ask for increase to QID (four times a day) and PRN. Staff failed to update the care plan to include this development or the ordered treatment.

The computerized nurse's notes on 5/2/13, identified the development of 2 new pressure ulcers to the resident's inner right and left buttocks. The staff conducted weekly assessments of the areas. Review of a MD/Nursing Communications form signed by the physician on 5/29/13 revealed an order to increase the Lantiseptic ointment to four times a day since there had not been any improvement in the pressure ulcer to the resident's right inner buttocks. Again, the staff failed to care plan the treatment to ensure staff followed the intervention.

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Interview with licensed nursing staff K on 8/14/13 at 3:17 p.m. revealed the staff tried to keep the resident's skin dry, moisture barrier Calmoseptine with every toileting, gel cushion in his/her chair. He/she was up ad lib (whenever the resident wanted) and he/she was just so thin, it was a challenge to keep them closed. When they were open, we would try Bactroban. I'm not really sure why the areas kept reopening. He/she ate pretty well, but he/she was just so thin and incontinent at times. He/she would allow the staff to reposition him/her most of the time, and he/she walked a lot.

The facility failed to review and revise the care plan for a resident that developed multiple pressure ulcers.

- Review of resident #31's admission MDS (Minimum Data Set) dated 11/13/12 revealed a BIMS (Brief Interview for Mental Status) score of 3, indicating severe cognitive impairment. The resident did not have any skin conditions, and required extensive assistance of one person for transfers and limited assistance of one person for walking in the room and corridor.

Review of the resident's quarterly MDS dated 5/16/13 revealed a BIMS score of 9, indicating moderately impaired cognitive impairment. The resident had moisture associated skin damage. The resident needed supervision with no assistance for walking in the room and the corridor, and supervision with setup help for transfers.

Review of the resident's care plan for anxiety/falls with a date of revision of 6/8/13 revealed interventions directing the staff to assist with personal care, perform 30 minute checks,

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personal tab alarm, speak clearly and slowly, allow to do for self as much as possible, assist with oral care, ensure dentures in place for meals, monitor for changes in balance/gait, notify the nurse of changes, assist with ambulation with a walker, assist to toilet after meals. The care plan noted a fall on 12/15/12, a fall on 6/2/13 with a skin tear to the right elbow, and a non-injury fall on 6/8/13.

Review of an Incident Investigation dated 6/2/13 revealed the resident had fallen and gotten a 2 cm (centimeter) skin tear to the right forearm.

Review of an Incident Investigation dated 6/8/13 revealed the resident had a non-injury fall and the skin assessment revealed an old scab to the right elbow and an old skin tear to the right forearm. Staff failed to include this skin tear on the care plan.

Review of an Incident Investigation dated 7/11/13 revealed the resident had fallen and sustained a 10 cm x 12 cm skin tear to the upper left forearm and a 4 cm x 5 cm skin tear to the lower left forearm that had been an old skin tear that reopened. No bruising noted. Staff failed to update the care plan to include this skin tear.

Interview with licensed nursing staff K on 8/14/13 at 3:17 p.m. revealed the resident had a skin tear on his/her left wrist/forearm area from a fall about 2 weeks or so ago.The bruises on his/her arms should be charted somewhere. I would look at the bruises to see if something new may have happened to have caused the bruises and it should be charted under wound/skin progress note. I know there is a new skin policy but I have only heard about it, I have not actually seen it. I would expect an incident report to be completed

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for bruises of unknown cause.

The facility failed to review and revise the care plan of a resident that experienced multiple skin tears to develop interventions to prevent re-occurences.

- Review of resident #25's Annual MDS (Minimum Data Set) dated 6/13/13 identified the resident with a BIMS (Brief Interview for Mental Status) score of 11 (indicated moderately impaired cognition). The assessment identified the resident required the limited assistance of one staff for personal hygiene, and had no skin issues noted, no applications of dressings, ointments or medications.

Review of the resident's care plan with an initiated date of 6/18/13 and next review date of 9/19/13 revealed it identified the resident had potential impairment to skin integrity related to urinary incontinence and decreased mobility. The resident also had moisture problems under his/her breast due to kyphosis and perspiration. It identified the resident had moisture issues and rash under breasts, hydrocortisone and coffee filters used to help keep dry and rash free, needed assistance to apply protective garments such as quilted boots, and needed pressure relieving to protect the skin while in recliner and wheelchair. It also identified the resident had a benign skin lesion to the right side of his/her neck. He/she had it for a very long time and it had been looked at by a dematologist who had ordered continued benign neglect of the neck lesion. It directed to avoid scratching and keep hands and body parts from excessive moisture, and continue benign neglect per doctor orders.

Review of a Nursing Progress Note dated

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F 280	Continued From page 34 8/13/2013 at 4:34 p.m. revealed the resident stated that arm has some tenderness. This nurse assessed arm and noted that resident had a small bruise with redness going up left arm and down the left side to mid back. This nurse called over to clinic and spoke with the doctor's nurse, who stated that the resident needed to be seen in clinic tomorrow. Review of a Nursing Progress Note dated 8/15/2013 at 10:09 a.m. revealed the resident resting in room, skin w/d (warm and dry), L FA (left ForeArm) skin tear with steri-strips intact/no drainage/edema/erythema (redness) noted, right upper arm with 1cm (centimeter) bruise and mild erythema/ no c/o (complaints of) pain, no requests at this time. Staff failed to update the care plan to include the bruises and skin tears. On 8/15/13 at 3:49 P.M. Administrative Nurse A stated that all bruises and skin tears should be documented on until cleared away. The facility failed to review and revise a care plan to include the development of bruises and skin tears for a resident.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This Requirement is not met as evidenced by: The facility census totaled 25 with 18 included in	F 309		

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the sample. The sample included the review of 3 residents with skin issues that were not related to pressure. Based on observation, interview and record review, the facility failed to provide routine monitoring of bruises and skin tears to ensure the skin issues healed without complications and failed to develop interventions to prevent additional occurrences of bruising and skin tears for 3 of the 3 residents sampled for skin issues. (#25, #26 and #31).

Findings included:

- The clinical record face sheet documented resident #31 admitted to the facility on 11/01/12. Physician ' s orders, dated 08/07/13, documented the resident ' s diagnoses included dementia, in conditions classified elsewhere with behavioral disturbances (progressive mental disorder characterized by failing memory, confusion with behavior exhibited).

The admission MDS (minimum data set), dated 11/13/12, revealed a BIMS (brief interview for mental status) score of 3, indicating severe cognitive impairment and the resident required extensive assistance of one person for transfers and limited assistance of one person for walking in the room and corridor.

The quarterly MDS, dated 5/16/13, revealed and identified the resident had moisture associated skin damage. The resident needed supervision with no assistance for walking in the room and the corridor, and supervision with setup help for transfers.

The CAA, dated 11/13/12, failed to trigger any area related to skin tears and/or bruising.

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The plan of care, dated 06/08/13, related to anxiety/falls, directed the staff to assist with personal care, perform 30 minute checks, and personal tab alarm. The plan of care failed to address the monitoring for or treatment of bruises, abrasions, and/or skin tears.

A facility Investigation, dated 6/2/13, revealed the resident had fell and received a 2 cm (centimeter) skin tear to the right forearm. The clinical record evidenced no further assessment, monitoring, or treatment of this skin tear.

A facility investigation, dated 6/8/13, revealed the resident had a non-injury fall and the skin assessment revealed an old scab to the right elbow and an old skin tear to the right forearm. The clinical record evidenced no further assessment, monitoring, or treatment of these injuries.

A facility investigation, dated 7/11/13, revealed the resident had fallen and sustained a 10 cm x 12 cm skin tear to the upper left forearm and a 4 cm x 5 cm skin tear to the lower left forearm that had been an old skin tear that reopened. No bruising noted. The clinical record evidenced no further assessment, monitoring, or treatment of these injuries.

A admit SPN (skin progress note) note, dated 8/7/13, revealed "no skin problems."

A skin/wound note, dated 8/9/13, revealed "skin assessment completed and no open areas found."

Observation, on 08/08/2013 at 03:54 pm, revealed the resident with a penny size scab to the left elbow and a large scab/abrasion to left

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forearm, a quarter sized bruise to the left forearm, and a large sized purple/green bruise to the right forearm, about the size of a deck of cards.

Interview with direct care staff C, on 8/13/13 at 8:40 a.m., reported he/she had taken the resident to the bathroom, assisted the resident to wash his/her hands, and walked with the resident to his/her chair. Staff reported the resident needed minimal assistance with ambulation and walked "pretty steady". Staff reported he/she had not noticed any skin conditions, but would report to the nurse any skin tears, breakdown, or bruising.

Interview with direct care staff G, on 8/13/13 at 2:52 p.m., revealed staff G would report any type of skin conditions that were abnormal for the resident, such as breakdown, bruising, rashes, skin tears. Staff G did not know of any skin issues the resident had at this time.

Interview with direct care staff J, on 8/14/13 at 11:19 am, revealed the resident had fragile skin and any bumps caused bruises and I think he/she may have had some bruises because of a fall a couple of weeks ago. I would report a bruise, skin tear, scab, or a fall, immediately to the charge nurse.

Interview with licensed nursing staff K, on 8/14/13 at 9:20 a.m., revealed he/she expected CNAs to report any skin changes or rashes.

Interview with licensed nursing staff K, on 8/14/13 at 3:17 p.m., revealed the resident had a skin tear on her left wrist/forearm area from a fall about 2 weeks ago. The bruises on his/her arms should be charted somewhere. I would look at the bruises to see if something new may have happened to have caused the bruises and it

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should be charted under wound/skin progress note. I know there is a new skin policy and but I have only heard about it, I haven't actually seen it. I would expect an incident report to be completed for bruises of unknown cause.

Interview with licensed nursing staff A, on 08/15/13 at 3:49 pm, revealed I would expect bruises, skin tears, redness, or skin abnormalities to be reported. If a CNA finds bruises of unknown cause, he/she should report to the charge nurse, and if there were no known cause, it would be investigated by me to determine if an incident report needed to be filed. Skin assessments had not been getting done routinely, so I plan to have weekly skin assessments done, head to toe and document any findings.

The facility policy and procedure, Skin and Wound Assessment, dated 02/01/05, evidenced, " ...To promote good skin integrity and to reduce/prevent skin issues ...Interventions ...will vary depending upon the etiology of the skin issue ...Bruises ...this area must be observed weekly by the shower staff and by the charge nurse, if the hematoma becomes worse or does not fade ... " The policy failed to address abrasions.

The facility failed to identify, adequately assess, monitor, and develop interventions to treat this resident ' s open area on the elbow and the bruising of both upper arms.

- Resident #26's clinical record face sheet documented the resident admitted to the facility on 04/15/13.

The admission MDS (minimum data set) assessment, dated 4/26/13, revealed a BIMS

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(brief interview for mental status) of 3, indicating severe cognitive impairment and the resident required limited assist of 1 staff for transfers, walking in room, and supervision of one for walking in corridor and no open lesions, surgical wounds, burns, skin tears or MASD (moisture associated skin damage).

The quarterly MDS assessment, dated 7/27/13, revealed a BIMS of 6 indicating severe cognitive impairment and identified the resident without skin issues.

Review of the Pressure Ulcer CAA (care area assessment), dated 4/26/13,, revealed the resident is less mobile and requires a walker to ambulate...care plan will focus on prevention, keeping resident clean and dry. The CAA failed to trigger any area related to skin tears and/or bruising.

The care plan, dated 05/14/13, failed to address the monitoring for or treatment of bruises, abrasions, and/or skin tears.

The TAR (treatment administration record), for August, 2013, revealed no documentation related to bruising or discolored areas on the resident's arms.

A progress Note, dated 08/09/2013 at 16:27 (4:27 pm) documented skin is intact with no redness. The clinical record lacked any further documentation or progress notes, from 7/30-8/15/13, which revealed any concern related to the resident ' s skin or bruising.

Observation on 08/13/13 at 10 08 am revealed the resident sat in his/her recliner. Noted multiple purple bruises, some larger than the size of a

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F 309	Continued From page 40 quarter, to left arm and wrist. Not in any pattern or specific shape. On 08/14/13 at 3:16 pm, certified staff G stated they were not aware of any skin tears or bruising. On 08/14/13 at 11:01 am, certified staff Q stated they had noticed a few bruises on the resident ' s arm, and when he/she fell last time, the resident got a skin tear which breaks open when he/she rubs it on the chair. Staff further stated they reported this to the nurse, but unsure if anyone else had. Staff stated, " I have not noticed any new ones [skin tears], [he/she] probably had the other one over a week or two ago. " Staff stated that if they see changes they let the nurse know, and they are the ones to monitor the areas to make sure they are healing. On 08/14/13 at 1230 pm, licensed staff K stated, " I expect them [certified staff or other licensed staff] to report skin issues to me. I go down and assess and see if needs treatment. If needs steri strips, I clean and stabilize the area. I have standing orders for steristrips. clean and stabilize. check daily and document on weekly. I know that will be changing, as [the facility] is working on a new skin policy and documentation on bruising also. Would have a skin/wound note if there is a treatment for the area then it will come up on the TAR. We didn ' t have a policy for that until over the weekend. Staff K reported the resident bruises easy, " Always has some bruising or discoloration ... " Interview with licensed nursing staff A, on 08/15/13 at 3:49 pm, revealed if they become aware of a resident with a skin tear, they turn it into charge nurse, the charge nurse then investigates to see if a cause can be determined.	F 309		

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If unable to determine the cause, then an incident report should be done. Depending on the incident report then we will look to see if the incident needs further investigation. We also notify doctor, and I have seen them notify the doctor of bruises also. Staff further stated there should be documentation on (the areas) until it heals and bruises should be documented on until cleared away.

The facility policy and procedure, Skin and Wound Assessment, dated 02/01/05, evidenced, " ...To promote good skin integrity and to reduce/prevent skin issues ...Interventions ...will vary depending upon the etiology of the skin issue ...Bruises ...this area must be observed weekly by the shower staff and by the charge nurse, if the hematoma becomes worse or does not fade ... "

The facility failed to identify, adequately assess, monitor, and develop interventions to ensure the treatment of this resident ' s bruising on the left arm and wrist.

- Resident #25 ' s clinical record face sheet documented the resident admitted to the facility on date 06/15/13.

The annual MDS (minimum data set), dated 6/13/13, revealed a BIMS (brief interview for mental status) score of 11, indicating moderately impaired cognitive status and no skin issues noted,

The CAA (care area assessment), dated 06/13/13, failed to trigger any area related to skin tears and/or bruising.

The care plan, dated 06/18/13, revealed the

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resident had a potential for impairment to skin integrity r/t incontinence and decreased mobility. The resident also had moisture problems under [the resident ' s] breast due to kyphosis and perspiration. Used protective garments such as quilted boots, and needed pressure relieving measures to protect the skin while in the recliner and the wheelchair. It also identified the resident had a benign skin lesion to the right side of her neck. The plan of care failed to address bruising for this resident.

The clinical record failed to evidence any documentation of skin issues from June 15th until 8/11/13.

On 8/11/2013 at 11:04 pm, a skin/wound note documented the resident had no adverse skin issues at this time.

On 8/13/2013 at 16:34 (4:34 pm) a Nursing Progress Note documented, resident stated that arm has some tenderness. This nurse assessed the arm and noted that resident had a small bruise with redness going up left arm and down the left side to mid back and an appointment with the physician was made.

On 08/15/2013 at 10:09 am, a nursing progress note, documented the resident ' s skin warm and dry, with a left forearm skin tear with steri-strips intact and no drainage/edema/erythema noted, and right upper arm with 1 cm (centimeter) bruise and mild erythema and no complaint of pain, no requests at this time.

The clinical record failed to evidence any documentation about the occurrence of a recent bruise on the resident ' s left hand.

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Review of the current TAR (treatment administration record), dated August, 2013, revealed an area of bruising presented on 5/31/13 on the resident ' s left hand and the facility staff were to monitor daily and document weekly. Staff had initialed this had been completed. The TAR failed to evidence the monitoring of a skin tear for this resident.

Observation, on 08/08/2013 at 03:07 pm revealed the resident with a bruise noted to left hand.

Observation and interview with the resident, on 08/15/13 at 10:00 am revealed he/she had a skin tear on his/her arm. At that time, the resident pulled up the left sleeve and revealed a nickel sized scabbed area to the left forearm covered with steristrips, and the area slightly red around the edges. The resident reported it did not hurt, and he/she thought he/she got it while asleep. The resident reported staff had come and looked at it pretty often, and said they came in yesterday to look at it.

Certified nursing staff G reported, on 08/14/13 at 3:09 pm that he/she had not seen any skin issue and would report to the nurse if he/she did.

Certified nursing staff Q reported, on 08/14/13 at 11:01 am, " I remember seeing a skin tear, the nurse had known about it. I remember seeing steri strips on it; I think it might be on the [resident ' s] left forearm.

On 08/14/13 at 1230 pm, licensed staff K stated, " I expect them [certified staff or other licensed staff] to report skin issues to me. I go down and assess and see if needs treatment. If needs steristrips, I clean and stabilize the area. I have standing orders for steristrips. clean and stabilize.

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check daily and document on weekly. I know that will be changing, as [the facility] is working on a new skin policy and documentation on bruising also. Would have a skin/wound note if there is a treatment for the area then it will come up on the TAR. We didn ' t have a policy for that until over the weekend. Staff K reported the resident bruises easy, " Always has some bruising or discoloration ... " [The resident] has a shoulder appointment today, has a little cellulitis on the right side - going to see physician today. no skin tears at the moment, [He/she].gets them on his/her left arm. He/she catches his/her arm on the corner of his/her furniture, but he/she doesn ' t want us to move the furniture... "

Interview with licensed nursing staff A, on 08/15/13 at 3:49 pm, revealed I would expect bruises, skin tears, redness, or skin abnormalities to be reported. If a CNA finds bruises or skin tears of unknown cause, he/she should report to the charge nurse, and if there were no known cause, it would be investigated by me to determine if an incident report needed to be filed. Skin assessments had not been getting done routinely, so I plan to have weekly skin assessments done, head to toe and document any findings. Areas should be documented on until they are healed. "

The facility policy and procedure, Skin and Wound Assessment, dated 02/01/05, evidenced, " ...To promote good skin integrity and to reduce/prevent skin issues ...Interventions ...will vary depending upon the etiology of the skin issue ...Skin tears ...these wounds must be observed daily for changes by the nurse or the CMA [certified medication aide] ...

The facility failed to identify,adequately assess,

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F 309	Continued From page 45 monitor, and develop interventions to ensure treatment of this resident ' s skin tear on the left forearm.	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This Requirement is not met as evidenced by: The facility census totaled 25 residents with 18 included in the sample. Two residents were reviewed for pressure ulcers. Based on interview and a closed record review, the facility failed to prevent the re-opening and worsening of multiple stage II pressure ulcers for 1 of 2 residents reviewed for pressure ulcers. The resident had pressure ulcers that developed, closed, and then redeveloped from 3/2013 through from 6/2013. (#10) Findings included: - Review of resident #10's signed physician orders dated 4/8/13 revealed the following diagnoses: anorexia (loss of appetite for food), dementia (progressive mental disorder characterized by failing memory, confusion), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). The resident had been admitted to the facility on	F 314		

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F 314	Continued From page 46 12/8/11. Review of an annual MDS (Minimum Data Set) dated 11/28/12 revealed a BIMS (Brief Interview for Mental Status) score of 8, indicating moderate cognitive impairment, and the resident did not exhibit behaviors of rejecting care. The assessment identified the resident required extensive assistance from one staff for bed mobility, independent when walking in the room/corridor, toileting, and required supervision with set up assistance from staff with personal hygiene, eating, was not at risk for the development of pressure ulcers and did not have any pressure ulcers. Review of a quarterly MDS dated 5/30/13 revealed a BIMS score of 5, (indicating severe cognitive impairment), and the resident did not exhibit behaviors including rejection of care. The resident required supervision with set up assistance from staff with bed mobility, walking in the room/corridor, was independent with transfers, and required supervision from one staff with toileting, and one person limited assistance with personal hygiene. The assessment identified the resident was at risk for the development of pressure ulcers, had two stage 2 pressure ulcers (Partial thickness loss of dermis-skin-presenting as a shallow open ulcer with a red-pink wound bed, without slough), received pressure ulcer care, was on a on a turning/repositioning program, and staff used a pressure relieving device on the chair and in bed. Review of the CAAs (Care Area Assessments) for Pressure Ulcers, ADL (Activities of Daily Living), and Nutritional Status dated 11/28/12 revealed staff failed to complete an analysis of findings. .	F 314		

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F 314	Continued From page 47 Review of the resident's pressure ulcer care plan, located in a chart at the nurse's station and revised by staff on 3/5/13 revealed the resident entered the facility (on 12/8/11) with a stage I and stage II on each buttock and the resident was at increased risk for more pressure ulcers due to a diagnosis of dementia, a history of pressure ulcers, medications, and the resident's choice to sleep in his/her recliner as he/she had done for the past 40 years. Interventions directed staff to complete a wound assessment and document the assessment at least every 7 days, notify the physician if no improvement in 2 weeks or if staff noted worsening in the wound at any time, provide Resource Breeze (a dietary supplement) three times a day. It also directed staff to conduct skin inspections with showers, Braden scale (assessment for risk of development of pressure ulcers) every 3 months and PRN (as needed), follow nutritional interventions, and encourage the use of pillows under one hip to offload buttocks slightly (changing every 1/2-1 hour) from 7 a.m.-1 a.m. daily. The resident slept in a recliner, encourage and supervise the resident to stand up for 5 minutes every 1/2-1 hour from 7 a.m. until 1 a.m., and give vitamin C, Zinc, multivitamin and healthy shots (dietary supplements) as ordered twice a day. On 6/13/12, staff added an intervention that identified the treatment of Xeroform (type of medication soaked in gauze), bandage powder (type of medicated powder), and Opsite (clear dressing) to left buttock's open area daily and PRN. Staff marked the area as resolved, but failed to date the entry onto the care plan. Staff changed the time for repositioning from every 1 and 1/2 hours to every 1/2-1 hour on 6/19/12. No further interventions had been added after 6/19/12.	F 314		

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F 314	Continued From page 48 Review of the resident's computerized pressure ulcer care plan, dated 3/13/13, revealed the resident had a Stage 2 pressure ulcer on the right inner buttock related to a history of pressure ulcers, choosing to sleep in his/her recliner rather than bed, his/her scooting down/sliding down in his/her recliner, and refusal to change position even with staff offering assistance. The interventions for staff included to administer treatments as ordered and monitor for effectiveness, assess/record/monitor wound healing weekly. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD (physician). The resident needed reminding and assistance with (or he/she will say ok and not change positions) to turn/reposition at least every 2 hours, more often as needed or requested. Monitor/document/report to MD PRN changes in skin status: appearance, color, wound healing, s/sx (signs/symptoms) of infection, wound size (length X width X depth), stage. Pressure relieving roho (brand of cushion) air cushion in his/her recliner at all times. The resident preferred to sleep in his/her recliner. He/she refused to sleep in his/her bed. Attempt to encourage and offer assistance with getting into bed if willing at least for a short period of time. Try alternative methods to gain compliance with position changes and sleeping in bed. Review of a physician's note dated 12/14/11 revealed the resident "really does not have any particular problems except he/she will not sleep in a bed because it hurts his/her back and has slept in a recliner for decades, resulting in small decubitus lesions (decubitus ulcer is essentially a hole caused by tissue death) on the sacral (triangular-shaped bone at the bottom of the	F 314		

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F 314	Continued From page 49 spine) area." Review of a Nursing Home Note for a physician visit on 3/13/13 revealed " PLAN: No change in treatment. He/she may have his/her nutritional supplements discontinued. The nurses did say that he/she has a pin hole size decubitus lesion on the coccyx and they would like to use Bactroban (Mupirocin Calcium ointment-unique topical agent recently developed for use in the treatment of superficial skin infections) on this t.i.d. [three times daily] until healed. This request will be ordered." Review of the Weekly Skin Documentation form revealed notes on 1/19/13 and 1/25/13 with no open areas noted. At that time, the facility did not use electronic charting. Review of the physician's orders revealed an order to apply Calmoseptine (multipurpose, moisture barrier ointment) ointment to right buttocks topically four times daily for skin breakdown prevention/pressure ulcer risk on the buttocks/coccyx. Review of the electronic Skin/Wound Notes revealed the following: 3/13/2013 Location: Right inner buttock Type of Wound: Stage 2 Pressure Ulcer Length (cm-centimeter) x Width (cm) x Depth (cm): 0.5cm (L) x 0.6cm (W) x superficial depth Drainage/Characteristics: Very light serosanguineous (wound drainage of a semi-thick reddish fluid) Narrative: Physician Assistant P in the building today and notified of new wound. New treatment orders received.	F 314		

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F 314	Continued From page 50 Review of a fax sent to the physician on 3/13/13 revealed the resident had a left buttock stage 2 pressure ulcer. Nursing asked for a "trial of Mucinoprin to site" three times a day. The physician sent a fax back in agreement that same day. 3/23/2013-Skin/Wound Note: Location: Open area to buttocks has closed, dry scab-like patch of skin remains. No other open areas noted. Mupirocin treatment continues as well as Calmoseptine for prevention. 3/27/2013 Location: Right inner buttocks. Type of Wound: Stage II Pressure Length (cm) x Width (cm) x Depth (cm): Area is resolved with clear pink skin. No dryness or scaling. Drainage/Characteristics: NA Narrative: Area to buttocks is resolved. Request from Physician to stop Calmoseptine due to drying and dc (discontinue) mupirocin routinely and start PRN for wounds. Review of a fax sent to the physician on 3/27/13 revealed the area to the right buttocks had resolved and asking to discontinue the mupirocin and change it to as needed. "Also believe Calmoseptine is drying. May we try no cream and observe for changes." The physician sent back a fax in agreement on 4/5/13. 4/1/2013-Skin/Wound Note Location: Coccyx Type of Wound: Pressure ulcer stage II Length (cm) x Width (cm) x Depth (cm): 0.8 X 0.4 X 0.2 cm Drainage/Characteristics: No noted drainage. Narrative: Skin assessment completed this AM	F 314		

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after shower. Noted new open area to coccyx, see above description. Start mupirocin to coccyx BID [twice a day] till resolved.

Review of a fax sent to the physician on 4/1/13 revealed the resident had a new open area to the coccyx. "Will restart mupirocin BID till resolved." The physician sent a fax back in agreement on 4/1/13.

4/8/2013-Skin/Wound Note
Location: Coccyx
Type of Wound: pressure
Length (cm) x Width (cm) x Depth (cm):
Resolved
Drainage/Characteristics: none
Narrative: Area is resolved with no further problems noted at this time.

Review of the physician's orders revealed on 4/8/13, the physician ordered staff to apply mupirocin kit 2% to coccyx topically one time daily and, Boost Breeze (dietary supplement) one juice box three times a day for skin breakdown prevention/pressure ulcer risk.

Review of a fax sent to the physician on 4/8/13 to notify the physician the area to the coccyx had resolved. "Mupirocin discontinued, May we use Lantiseptic to buttocks BID [twice a day] for prevention." The physician sent back a fax in agreement.

Review of a Nursing Home Note for a physician visit on 4/10/13 revealed the resident "did have some small decubitus lesions that were not fully healed and medication treatment for these lesions has been discontinued."

Review of a physician order dated 4/16/13

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revealed the physician's order for Mupirocin was dc'd on 4/16/13 due to the area resolved.

4/25/2013-Skin/Wound Note
Location: Left inner buttocks near coccyx.
Type of Wound: Stage II pressure
Length (cm) x Width (cm) x Depth (cm): 0.3cm x 0.3cm x 0.2cm
Drainage/Characteristics: no drainage or discharge noted
Narrative: Resident in shower with assist of one. Noted to have a new open area to left buttocks near coccyx. Resident has order for Lantiseptic (Skin Protectant with a high-lanolin formula) ointment twice a day and PRN. Will ask for increase to QID (four times a day) and PRN.

Review of a fax sent to the physician on 4/26/13 revealed the resident had a new open area to the left buttock and nursing asked for the Lantiseptic to be increased to four times a day until healed. The physician sent back a fax the same day in agreement.

5/2/2013 Skin/Wound Note Late Entry:
Location: Left inner buttock
Type of Wound: pressure
Length (cm) x Width (cm) x Depth (cm): 0.8 x 0.5 x 0.2
Drainage/Characteristics: none
Narrative: wound is slightly more open, wound bed pink, no slough noted.

5/2/2013 Late Entry:
Location: Right inner buttocks
Type of Wound: pressure
Length (cm) x Width (cm) x Depth (cm): 0.5 X 0.5 X 0.2 cm
Drainage/Characteristics: no noted drainage
Narrative: area is slightly larger. Resident asked

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F 314	Continued From page 53 to lie down for a short time several times each day but will not always do so. Review of a Nursing Home Note for a physician visit on 5/8/13 revealed no mention of any skin issues. 5/9/2013 Late Entry: Location: Left inner buttocks Type of Wound: pressure Length (cm) x Width (cm) x Depth (cm): 1 x 0.5 x 0.2 cm Drainage/Characteristics: none Narrative: resident has clean pink wound bed. No s/s (signs/symptoms) of infection. 5/9/2013 Late Entry: Location: Right inner buttocks Type of Wound: pressure Length (cm) x Width (cm) x Depth (cm): 0.5 x 0.4 x 0.2 cm Drainage/Characteristics: none noted Narrative: very small improvement noted in size. Area remains clean and free of s/s (signs/symptoms) of infection. 5/16/2013 Late Entry: Location: Left inner buttocks Type of Wound: pressure Length (cm) x Width (cm) x Depth (cm): 1 X 0.75 x 0.2 cm Drainage/Characteristics: none Narrative: noted larger area, continues to be free of infection and has pink granulated (healing tissue) wound bed. 5/16/2013 Late Entry: Location: left inner buttock Type of Wound: pressure	F 314		

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F 314	Continued From page 54 Length (cm) x Width (cm) x Depth (cm): 0.5 X 0.5 X 0.25 cm Drainage/Characteristics: none Narrative: noted slight increase in size, no s/s of infection. 5/16/2013 Late Entry: Location: right inner buttocks Type of Wound: pressure Length (cm) x Width (cm) x Depth (cm): 0.5 x 0.3 x 0.2 Drainage/Characteristics: no noted drainage Narrative: slight improvement noted. Continues to have pink wound bed with granulated tissue noted 5/23/2013 Late Entry: Location: Left inner buttocks Type of Wound: pressure Length (cm) x Width (cm) x Depth (cm): 0.5 x 0.25 x 0.2 Drainage/Characteristics: none Narrative: no changes noted to wound. No s/s of infection. Wound beds are pink and granulated. 5/23/2013 Late Entry: Location: Right inner buttocks. Type of Wound: Pressure Length (cm) x Width (cm) x Depth (cm): 0.5 x 0.25 x 0.2 Drainage/Characteristics: none Narrative: Area has good granulated wound bed, no s/s of infection 5/24/2013 Late Entry: Location: Right inner buttocks Type of Wound: pressure Length (cm) x Width (cm) x Depth (cm): 0.5 x 0.25 x 0.2 cm Drainage/Characteristics: none	F 314		

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F 314	Continued From page 55 Narrative: area remains much the same. No s/s of infection. Continue current treatment and monitoring schedule. 5/24/2013 Late Entry: Location: Left inner buttocks Type of Wound: pressure Length (cm) x Width (cm) x Depth (cm): 1.25 x 0.75 x 0.2 cm Drainage/Characteristics: none Narrative: Area has pink granulated wound bed. No s/s of infections. Continue treatment as ordered 5/26/2013 Location: Right inner buttocks Type of Wound: pressure Length (cm) x Width (cm) x Depth (cm): 0.5 x 0.25 x 0.2 Drainage/Characteristics: none Narrative: Area not improved increasing treatment to QID, Physician Assistant P Review of a MD/Nursing Communications form signed by the physician on 5/29/13 revealed an order to increase the Lantiseptic ointment to four times a day since there had not been any improvement in the pressure ulcer to the resident's right inner buttocks. 5/26/2013-Skin/Wound Note Location: Left inner buttocks Type of Wound: pressure Length (cm) x Width (cm) x Depth (cm): 1.25 x 0.75 x 0.2 cm Drainage/Characteristics: none Narrative: Area shows no sign of improvement Physician Assistant P notified and treatments increased to QID.	F 314		

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F 314	Continued From page 56 5/31/2013 Location: Left buttocks Type of Wound: pressure Length (cm) x Width (cm) x Depth (cm): 1.3 x 0.5 x 0.1 cm Drainage/Characteristics: no noted drainage. Narrative: Slight improvement noted in size. Call to doctor ' s office to report to Physician Assistant P. Message left and report faxed to Physicians office. A Braden Scale for Prediction of Pressure Sores completed on 5/30/13 revealed the resident had no sensory impairment, his/her skin was occasionally moist, had no limitation in mobility and walked occasionally, "probably" had inadequate nutritional intake, and had a potential risk for friction and shear. These indicators gave the resident a score of 18 that indicated the resident had a low risk for developing a pressure ulcer. Interview with direct care staff H on 8/13/13 at 3:50 p.m. revealed the resident had interventions in place for a Roho (brand of cushion) cushion in his/her chair, staff had to convince the resident to lay in the bed for at least 15 minutes, Calmoseptine for his/her bottom, dry incontinence products, clean skin. During the day, he/she would not stay in the bed for very long. At night, he/she would sleep in the bed for an hour or so. Once the areas closed, some CNAs (Certified Nurse Aides) think they don't need to worry about it anymore, so they just stop doing the interventions, like the Calmoseptine and turning. Interview with direct care staff J on 8/14/13 at 11:19 a.m. revealed there were interventions to encourage the resident to walk more, reposition him/her, padding in the chair, Calmoseptine	F 314		

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ointment to the area, making sure his/her incontinence products were dry, cleaning the area. The resident had been pretty independent and only occasionally incontinent. The resident spent a lot of time in his/her chair and did not like to be in the bed. He/she did slide down in his/her chair and wiggled.

Interview with licensed nursing staff K on 8/14/13 at 3:17 p.m. revealed the staff tried to keep the resident's skin dry, moisture barrier Calmoseptine with every toileting, gel cushion in his/her chair. He/she was up ad lib (whenever the resident wanted) and he/she was just so thin, it was a challenge to keep them closed. When they were open, we would try Bactroban. I'm not really sure why the areas kept reopening. He/she ate pretty well, but he/she was just so thin and incontinent at times. He/she would allow the staff to reposition him/her most of the time, and he/she walked a lot.

Interview with administrative nursing staff A on 8/15/13 at 5:15 p.m. revealed if a resident had an open area, the doctor should be notified to obtain a treatment order, changing the resident's position at least every 2 hours or more often, documenting on the status of the wound during treatments with measurements and drainage, document a skin note. If an area closed, it still needed to be monitored closely, weekly skin assessments to be sure it didn't re-open. If a resident had pressure ulcers that re-opened frequently, they should have been sent to see a wound specialist.

During an interview on 8/20/13 at 4:13 p.m., physician assistant P reported that the resident had been admitted to the facility with some

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lesions on his/her buttocks. Physician assistant P confirmed the resident had multiple stage II pressure ulcers that closed and reopened many times and had not seen a wound care specialist because the pressure ulcers had been very small and managed with the skin creams and treatments the facility had been using. Physician assistant P reported that contributing factors that led to the ulcers reopening frequently were thinning skin, sedentary lifestyle, and frailty and reported the resident did walk, but spent a lot of time sitting. Physician assistant P reported the resident had a chair cushion to prevent pressure. Physician assistant P reported that he/she did not know if the reopening of the pressure ulcers had been unavoidable.

Review of the facility's policy on Skin Care, dated 2/1/05, identified the staff were to determine the cause of the skin impairment. If staff identified the impairment was the result of a pressure ulcer, then:

"a. Each nurse will be trained by the continuing education units and by in house in-services in the area of wound assessment and treatment. The Assistant Director of Nursing will be the lead wound nurse for any areas of clarification. The physician or the physician extender or Nurse Wound Consultant will also serve to clarify the etiology of any wound that is questionable.

b. Special emphasis will be put on prevention. This will be done by risk assessment as shown by the Braden Scale and any other outstanding factors such as history of previous pressure ulcers, active dying phase, end stage system failure, para/quad/or hemiplegia, casts or splints.

c. Any elder that is identified upon admission or upon quarterly, annual, or significant change assessment is shown to be at risk by the Braden

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F 314	Continued From page 59 Scale or has one of the other predisposing factors listed above will be placed on high risk precautions. 4. High Risk Precautions Any elder that is assessed by the MDS Coordinator or the Director of Nursing as being at high risk for skin break down will trigger the initiation of the high risk skin breakdown prevention protocol. a. Weekly skin assessment (shower/bath) as stated previously. b. Pressure reduction devices in wheel chair and in the bed, and any other surface the elder would be in for more than 2-hour consecutive time frame. c. If the elder is in bed for an extended amount of time heel protectors of the elder ' s choice will be used. d. Depending on the nature of the area of pressure risk that particular part of the body must be off-loaded as much as possible. Examples: O2 padding if continuous O2 use, leg strap if Foley catheter, padding around a cast." The facility failed to assess open areas weekly. The facility failed to provide continuous preventative treatments to the inner buttocks and coccyx for a resident that had multiple pressure ulcers develop, heal, then re-open from 3/2013 until 5/2013.	F 314		
F 315 SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315		

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who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This Requirement is not met as evidenced by:
The facility census included 25 residents with 18 included in the sample. Based on observation, record review, and interview, the facility failed to follow the incontinence program and maintain, prevent decline, or improve urinary continence for 2 of 4 sampled residents reviewed for urinary incontinence (#34 and #13). Resident #34's urinary continence declined over a 3 1/2 month period.

Findings included:

- Review of resident #34's signed physician orders dated 8/10/13 revealed a diagnosis of vascular dementia (a condition affecting brain function caused by multiple small blood clots in the brain). The resident admitted to the facility on 4/23/13.

Review of the admission MDS (minimum data set) dated 5/2/13 revealed a BIMS (brief interview for mental status) score of 2, indicating severe cognitive impairment. The resident required setup assistance for transfers, was independent with setup assistance for toileting, and required supervision with setup assistance for walking in the room and corridor. The resident had not had any falls. The MDS identified the resident as always continent.

Review of the quarterly MDS dated 8/2/13 revealed the resident had problems with short

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F 315	Continued From page 61 and long term memory recall, continuous inattention, moderately impaired decision making, and continuous disorganized thinking. The resident required extensive assistance of one person for transfers, walking in the room and corridor, dressing, and toileting. The resident had been on a toileting program and was frequently incontinent of urine (7 or more episodes of urinary incontinence, but at least one episode of continent voiding during the 7 day lookback period). Review of the Cognitive Loss/Dementia CAA (care area assessments) dated 5/7/13 revealed an analysis of findings of: "Resident very confused and has more difficulty during late afternoon and evening." Review of the resident's CAAs dated 5/7/13 revealed the Urinary Incontinence and the ADL (activities of daily living) Functional/Rehabilitation Potential CAAs did not trigger. Review of the resident's care plan for ADL assistance with a revision date of 5/29/13 revealed the resident required assistance of cueing with short, simple instructions, such as "hold your brush", "wash your hands" for personal hygiene care. The care plan lacked anything indicating the resident had incontinent episodes or required assistance with toileting. Review of a "Bowel and Bladder Program Screener" dated 5/2/13 revealed the resident toileted Independently, with reasonable speed, was always aware of the need to toilet, and not always, but at least daily voided appropriately without incontinence. The resident had a score of 19, which identified the resident as a good candidate for bladder retraining.	F 315		

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F 315	Continued From page 62 Review of a "Bowel and Bladder Program Screener" dated 6/20/13 revealed the resident required assistance of one staff, was sometimes aware of need to toilet, and not always, but at least daily voided appropriately without incontinence. The resident had a score of 14, which identified the resident as a candidate for scheduled toileting. Review of a "Bowel and Bladder Program Screener" dated 8/2/13 revealed the resident required assistance of one staff, was sometimes aware of need to toilet, and less than daily voided appropriately without incontinence. The resident had a score of 12, which identified the resident as a candidate for scheduled toileting. Review of the nurses notes from 4/ 25/13 - 8/15/13 revealed no mention of increasing incontinence or possible contributing factors. Review of the resident's chart revealed it lacked documentation of a toileting program. Observation on 8/13/13 at 8:05 a.m. revealed direct care staff D went into the resident's room where the resident lay in bed and offered to get him/her up for a shower, and the resident declined. Staff C then asked the resident if he/she needed to go to the bathroom and the resident declined. Observation on 8/13/13 at 8:42 a.m. revealed direct care staff members C and D went into the resident's room where the resident lay in bed and offered to get him/her up for a shower, and the resident declined. Staff C then asked the resident if he/she needed to go to the bathroom and the resident declined. Observation on 8/13/13 at 9:55 a.m. revealed	F 315		

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administrative nursing staff B and direct care staff D assisted the resident to sit on the side of the bed and then ambulate to the bathroom. The resident wore a wet incontinence brief and urinated in the toilet.

Observation on 8/13/13 at 12:19 p.m. revealed direct care staff D went into the resident's room and offered to take him/her to the bathroom, and the resident declined. Staff D forgot his/her gait belt, then went to retreive it, came back and offered to take the resident to the bathroom again, and the resident again declined. Staff D then assisted the resident to walk to the dining room.

Interview with direct care staff D on 8/13/13 at 10:04 a.m. revealed the resident could tell staff he/she needed to go to the bathroom if staff offered to take the resident, but the resident did not ask to go to the bathroom. Staff D identified the resident as usually continent.

Interview with direct care staff H on 8/13/13 at 3:50 p.m. revealed when the resident first came in, he/she had urinary continence and toileted him/herself, but had more incontinence when the resident slept. Staff H identified the resident as incontinent now and needed assistance of one to two staff for toileting, depending on how the resident felt and his/her mood.

Interview with direct care staff J on 8/14/13 at 11:19 a.m. revealed the resident had been continent for the most part when he/she first came in to the facility, but now had much more frequent incontinence. Staff J reported the resident did not have a toileting program in place but staff offered to take the resident to the bathroom every few hours and the resident could

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tell staff when he/she thought he/she needed to urinate. Staff J reported the resident's health had been going downhill and that could be why the resident's continence had gotten a little worse.

Interview with licensed nursing staff K on 8/14/13 at 3:31 p.m. revealed the resident required assistance of one for toileting and was mostly incontinent, but it his/her continence fluctuated based on how the resident felt. Staff K confirmed that if the staff asked the resident, he/she could tell the the staff if he/she needed to go to the bathroom. Staff K reported the staff toileted the resident at least every two hours. Staff K confirmed when the resident first came to the facility, he/she had required less assistance with toileting. Staff K reported the resident had a health decline and his/her dementia had gotten worse and attributed that to why the resident required more assistance and had a decline in continence.

Interview with administrative nursing staff A on 8/15/13 at 5:15 p.m. revealed he/she expected the care plan to include how much assistance the resident required with toileting, when to toilet, toileting at least every 2 hours, and if the resident had a voiding pattern. Staff A reported he/she did not know what kind of assessments were done during admission, but a continence assessment would be helpful that included when the resident voided, how frequently, and how much assistance the resident needed.

During an interview on 8/20/13 at 3:10 p.m. with physician O revealed he/she was unsure of why the resident had become increasingly incontinent and did not know enough about the resident's voiding patterns to know if the resident had frequency, urgency, or what the issue may be.

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Physician O confirmed the resident may have benefitted from a toileting program.

Review of the facility policy for Toileting and Perineal Care, last revised 5/29/09, revealed, "The goal is to prevent incontinence for as long as possible. ... 1. Upon admission continence, type of incontinence, and risk for skin breakdown will be done. Throughout assessment week, continence will be evaluated and assessed ... If functional incontinence of bowel and bladder is identified, absorbent products will be provided and a check and change program may be initiated. A basic check and change program would be at rising in the AM, after meals, and at bed time as well as PRN [as needed], but no more than two hours between checks ... If the incontinence is due to frequency or urgency, then the physician will be notified to check to see if a medication may be appropriate ... If the incontinence is due to a physical disability, a toileting plan may be initiated."

The facility failed to determine causal factors and develop and implement interventions to prevent decline in resident #34's urinary continence.

- Review of resident #13's electronic record revealed the resident admitted to the facility on 12/18/12 with a diagnosis of urinary incontinence. The electronic record identified the resident obtained the following diagnoses after the resident admitted into the facility: chronic kidney disease (progressive loss in renal function over a period of months or years), urinary tract infection, type II diabetes with renal manifestations (A syndrome occurring in people with diabetes mellitus; associated with damage to blood vessels that supply the kidney; characterized by albuminuria-high albumin levels in the urine,

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hypertension-elevated blood pressure, and progressive renal insufficiency-kidneys' worsening ability to filter waste from the blood), not acute (sudden onset) or chronic (occurs long-term) nephritis (inflammation of one or both kidneys) and nephropathy (kidney disorder), and personal history of urinary tract infections.

Review of the annual MDS (Minimum Data Set-a required assessment) dated 1/9/13, identified the resident with a BIMS (Brief Interview for Mental Status) score of 15/15 (indicated the resident had little to no cognitive impairment), exhibited behaviors that affected others 1-3 days out of the last 7, and behaviors that did not affect others 4-6 days out of the last 7. The assessment identified the behaviors impacted the resident's care, and identified the resident rejected assistance with care 1-3 days out of the last 7. The assessment identified the resident as dependent on 2 staff for bed mobility, transfers, toileting, and personal hygiene, always incontinent of bladder and not on a toileting program.

Review of the quarterly MDS dated 7/4/13, identified the resident with a BIMS of 15, rejected care 1-3 days out of the last 7, required the extensive assistance from 2 staff with bed mobility, transfers, toileting, personal hygiene, always incontinent of urine and not on a toileting program. This assessment identified an improvement in the resident's behaviors and physical abilities to assist with ADLs (Activities of Daily Living).

Review of the Urinary Incontinence CAA (Care Area Assessment-a further assessment) worksheet, dated 1/9/13, identified the following: "Resident refuses to allow routine check and changes. Resident refuses to sit on the bedside

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commode or toilet for urination or on a daily basis to assist with bowel movements. Resident has had long term institutionalization and uses areas of care such as toileting as a form of control despite his/her choices being poor and leading to other health problems such as UTIs (Urinary Tract Infections) and pressure ulcers. Resident will be incontinent of urine and refuse to have proper peri-care. He/she will also be incontinent of urine and refuse to have his/her position changed or moved to the bed so that urine absorbing products can be changed and peri-care provided. Resident previously had long term use of Foley catheter. Refused the replacement of the Foley catheter for a reason he/she will not discuss. He/she denies the ability to recognize the need to urinate. Resident takes in large amounts of fluid daily and has been known to cause him/her to be fluid overloaded. Dependent on staff for cares but is cognitive and refuses the care he/she needs for proper urinary incontinence interventions. Resident had no input and denied his/her refusal to accept cares. The resident stated he/she rang for assistance when he/she was wet and that staff refused to provide him/her care which is not accurate. Resident refuses appropriate interventions to prevent complications such as UTIs, yeast infections, skin breakdown, and pressure ulcers. Staff can only provide interventions that he/she is agreeable to when he/she chooses them which makes avoiding complications and minimizing risks very difficult. Resident has been educated numerous times on the potential complications including infections and possible death."

Review of the care plan, dated 10/18/12 and last reviewed 7/11/13, identified the resident required extensive to total assistance for all ADL's except eating, a history of chronic occurrence of UTI's

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and Chronic Kidney Disease, had a Foley catheter in place for over two years and recently asked to have the catheter changed due to urinary leakage and then refused to have the catheter put back in. The care plan indicated the resident was incontinent of urine and due to his/her refusal to use the bed side commode except for rare instances. The care plan directed the staff to encourage the resident to use the bed side commode at least once per day and when feeling the urge to have a bowel movement. The care plan indicated the resident did not want routine check and changes, and identified he/she would call for assistance when he/she was wet with urine and wanted to be changed.

Review of the electronic record revealed it lacked an assessment of the resident's type of urinary incontinence or habits/patterns.

Observation on 8/13/13 at 9:15 a.m. revealed the resident asked Direct care staff E if he/she would change the resident. Staff member E reported to the resident he/she would find someone to help him/her.

On 8/13/13 at 9:20 a.m., observation of Direct care staff E and Direct care staff C revealed the staff changed the resident's brief as the resident lay in bed. Observation at that time revealed the resident's left inner thigh red, perineal area slightly red, and buttocks red. Staff C reported at that time the resident's brief was saturated with urine. Staff C applied Vaseline gauze to the resident's left inner thigh, applied "bag balm" to the resident's bottom, and then applied a new brief under the resident. Staff E and C did not tape the brief shut but left the brief lay loosely on the resident's stomach. Staff E reported at that time the staff applied the brief loosely to prevent

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rubbing to the left inner thigh, and that the redness located to the left inner thigh was from the brief rubbing.

On 8/13/13 at 7:30 a.m. the resident revealed he/she had not been changed yet that morning. The resident stated he/she asked to be changed around 7:00 am and asked staff C to change him/her. Staff failed to change the resident until 9:15 a.m., over 2 hours later.

On 8/13/13 at 3:42 p.m., interview with direct care staff G revealed he/she checked the resident every two hours and in between if the resident rang to be changed. Staff G reported the resident was "pretty good" about ringing and letting staff know when he/she was wet.

Review of a log, identified as a "Two Hour Check and Change" log, revealed on 8/13/13 staff documented they had changed the resident at 3:45 a.m., then again at 7:15 a.m., 3 and 1/2 hours later. Further documentation on the same day revealed staff changed the resident at 9:00 a.m., 10:00 a.m. and 11:30 a.m. The documentation showed the next time staff changed the resident's incontinent brief was at 9:00 p.m., or 9 and 1/2 hours later.

Review of the log dated 8/14/13, revealed the first time staff changed the resident was at 4:45 a.m., almost 8 hours after the last change, then again at 8:00 a.m., or over 3 hours later.

On 8/14/13 at 8:39 a.m. interview with direct care staff J reported staff checked all residents identified with urinary incontinence about every 2 hours and applied barrier cream to their bottoms with peri care. Staff J identified that for resident #13, staff checked him/her every two hours and

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sometimes more often. Staff J said the resident very rarely refused to be changed. Staff J stated the resident was able to voice when he/she needed to be changed and it usually took 5-10 minutes to get back in to the resident once he/she requested to be changed. Staff J said the facility had started to document on a log when they changed him/her. Staff J said the staff documented the care as soon as they finished. Staff J identified the log was "a new thing" in the past 2-3 weeks because the resident had accused staff of not changing him/her or taking care of him/her. Staff J stated the staff were still getting used to filling out the log.

On 8/14/13 at 11:57 a.m., Licensed Nurse K reported the resident was incontinent of urine and staff kept a log to show when staff checked and changed the resident. Nurse K said the resident had told the physician that the facility was not changing him/her, so the physician came and looked at the spot, noticed a red spot-probably from shearing-about the size of a quarter and ordered the Vaseline gauze to be applied. After the physician came to the facility, the staff started keeping a log of when staff changed him/her. Also the resident refused sometimes to be changed if he/she gets mad. Nurse K looked at the log and confirmed on 8/13/13 that from 1:30-9:00 pm staff had failed to document they changed the resident's brief.

On 8/15/13 at 5:35 p.m. Administrative Nurse A reported the resident complained staff were not checking or changing him/her every 2 hours. Administrative Nurse A said he/she asked the staff if they were checking the resident every two hours and they confirmed they were. So, in order to help prove that they were checking and changing the resident, Administrative Nurse A

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F 315	Continued From page 71 started a 2 hour check list for the staff to document the occurrences. Nurse A said that he/she thought staff had forgotten to document when they had cared for the resident, so nurse A reported that now the charge nurse would be responsible for making sure the staff documented on the checklist. Nurse A confirmed staff had not documented they had provided incontinent care every 2 hours. Review of the facility policy for Toileting and Perineal Care, last revised 5/29/09, revealed, "The goal is to prevent incontinence for as long as possible. ... 1. Upon admission continence, type of incontinence, and risk for skin breakdown will be done. Throughout assessment week, continence will be evaluated and assessed ... If functional incontinence of bowel and bladder is identified, absorbent products will be provided and a check and change program may be initiated. A basic check and change program would be at rising in the AM, after meals, and at bed time as well as PRN [as needed], but no more than two hours between checks ... If the incontinence is due to frequency or urgency, then the physician will be notified to check to see if a medication may be appropriate ... If the incontinence is due to a physical disability, a toileting plan may be initiated." The facility failed to ensure staff followed the planned incontinence program of check and change every 2 hours for this dependent, incontinent resident.	F 315		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323		

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F 323	Continued From page 72 adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility census totaled 25 residents, with 18 included in the sample. Four residents were reviewed for accidents. Based on interview, record review, and observation, the facility failed to thoroughly investigate all falls and implement appropriate fall interventions to prevent accidents for 2 of 4 residents (#34, #26), resulting in a fractured thumb for resident #34. The facility also failed to prevent accidents due to unsecured chemical storage for 6 cognitively impaired, independently mobile residents. Findings included: - Review of resident #34's signed physician orders dated 8/10/13 revealed the following diagnoses: chronic orthostatic hypotension (low blood pressure with position changes), vascular dementia (a condition affecting brain function caused by multiple small blood clots in the brain), and weakness. The resident admitted to the facility on 4/23/13. Review of the admission MDS (minimum data set) dated 5/2/13 revealed a BIMS (brief interview for mental status) score of 2, indicating severe cognitive impairment. The resident had minimal hearing loss, wore hearing aides, usually made him/herself understood, understood others, and had adequate vision. The resident required setup assistance for transfers, was independent with setup assistance for toileting, and required supervision with setup assistance for walking in	F 323		

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the room and corridor and eating. The resident had not had any falls.

Review of the quarterly MDS dated 8/2/13 revealed the resident had problems with short and long term memory recall, continuous inattention, moderately impaired decision making, and continuous disorganized thinking. The resident had highly impaired hearing, wore hearing aides, impaired vision, wore glasses, usually made him/herself understood, and understood others. The resident required extensive assistance of one person for transfers, walking in the room and corridor, dressing, and toileting. The resident had occasional moderate pain, had two or more minor injury falls since the previous assessment, and one fall with major injury.

Review of the Cognitive Loss/Dementia CAA (care area assessments) dated 5/7/13 revealed an analysis of findings of: "Resident very confused and has more difficulty during late afternoon and evening."

Review of the Falls CAA dated 5/7/13 revealed an analysis of findings of: "Resident wanders throughout the facility with and without walker or cane. Fall potential is high due to unsteadiness."

Review of the fall risk assessment dated 5/2/13 revealed the resident had a fall risk score of 7, indicating moderate risk.

Review of the fall risk assessment dated 8/2/13 revealed the resident had a fall risk score of 16, indicating high fall risk.

Review of the resident's care plan for impaired cognitive function with a date of revision of

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5/29/13 revealed interventions directing staff to reduce any distractions (turn off TV, radio, close door), use consistent, simple, directive sentences, provide the resident with necessary cues, stop and return later if the resident became agitated, engage the resident in simple, structured activities that avoid overly demanding tasks, keep the resident's routine consistent, try to provide consistent care givers as much as possible in order to decrease confusion, and monitor/document/report to the physician any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, or mental status.

Review of the resident's care plan for fall risk with a revision date of 5/29/13 revealed interventions directing staff to ensure that the resident wore appropriate footwear (his/her black shoes or tan slippers) when ambulating, provide activities that minimize the potential for falls while providing diversion and distraction (like one on one conversations and small groups), use a personal tab alarm in bed and while up to alert staff when the resident may need assistance (added 7/29/2013), and provide 30-minute visual checks (added 6/10/13).

Review of the resident's care plan for limited physical mobility last revised 6/6/13 revealed it directed staff to remind the resident to get his/her walker if the resident forgot it or to get it for the resident if he/she moved too far away from it.

Review of a Fall Investigation Form dated 5/9/13 revealed the resident had ambulated in the hall by the dining room, dragging a chair, lost his/her balance, and fell. The resident hit his/her head

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(right cheek) on the hand rail and the back of his/her hand on the floor. The resident complained of right knee and hip pain and was transported by EMS (emergency medical services) to the ER (emergency room) for evaluation and treatment. The staff obtained vital signs, initiated neurological checks (a system for checking changes in brain function). Potential contributing factors included dementia and the resident took antianxiety and blood pressure medications. The charge nurse notified the physician, family, DON (director of nursing), and the administrator. Staff identified the resident toileted him/herself, attempted to move a chair and did not say why, and used a cane. The form indicated staff reviewed the care plan, but did not revise it. Statements had not been obtained by any witnesses or the staff member that found the resident after the fall.

Review of a Nursing Progress Note dated 5/9/13 at 7:10 p.m. revealed the resident fell in the hall and hit his/her head and complained of right hip and right knee pain. Staff sent the resident to the ER for evaluation and treatment.

Review of a Nursing Progress Note dated 5/9/13 at 9:00 p.m. revealed the resident returned from the ER with new orders for Lortab (a narcotic pain medication) and a new diagnosis of a knee effusion (excess fluid that accumulated in or around the knee joint) with an elastic wrap to the knee for support.

Review of a Nursing Progress Note dated 5/9/13 at 9:12 p.m. revealed staff received no new orders for the resident's knee and the resident stated his/her knee hurt and the resident knew he/she should stay off of it and elevate it.

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Review of a Nursing Progress Note dated 5/12/13 at 4:00 p.m. revealed the resident received a dose of Lortab for complaints of right knee pain.

Review of a Nursing Progress Note dated 5/24/13 at 10:15 a.m. revealed the resident had gone to the clinic for an appointment regarding his/her right knee, as it had been swollen, red, warm to the touch, and tender to palpation (touch).

Review of an Incident Investigation form dated 6/10/13 revealed staff found the resident on the floor in the bathroom. The resident complained of back pain, had a bruise to the buttock, and went to the ER at the family's request. Staff completed vital signs and neurological checks. The form identified the resident had been trying to go to the bathroom, and the resident could not use a call light appropriately. The resident took diuretic, cardiovascular, and antidepressant medications that may have contributed to the incident. Staff initiated 15 minute visual checks (staff failed to update the care plan which directed staff to provide 30 minute visual checks), and the physician and family were notified. A note on the form indicated, "Need tabs alarm for resident." No statement was obtained from the staff member that found the resident.

Review of an Incident Investigation form dated 6/22/13 at 5:45 p.m. revealed staff found the resident sitting on the floor in the living room on his/her wheelchair pedals and the wheelchair tilted forward with the chair cushion 25% forward in the seat. The nurse saw the resident 5 minutes prior to staff finding the resident on the floor. Staff obtained vital signs. Potential contributing factors included vascular dementia, a hospitalization within 30 days prior, a room change in the past 72

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hours, and the resident received diuretic, narcotic, and antipsychotic medications that may have contributed. Staff toileted the resident before the evening meal and found no injuries after the fall. Staff reviewed the care plan, but had not updated it. Staff notified the family, physician, and DON. A note written on the form included, "Need to assess need for personal alarm when up in w/c [wheelchair]". A witness statement had been obtained by the staff member that found the resident.

Review of the resident's 15 minute visual check log for 6/22/13 revealed staff completed no visual checks between 2:15 p.m.-5:45 p.m., during the time when the resident fell.

Review of an Incident Investigation form dated 7/28/13 at 1:50 p.m. revealed staff found the resident on the living room floor on his/her buttocks. The resident sustained a rug burn to the right knee with no other injuries noted. Staff completed vital signs, neurological checks, and notified the family and physician. Potential contributing factors were weakness, resident had been in an unsupervised area, and received diuretic, narcotic, and antipsychotic medications that may have contributed. Staff had toileted the resident at 12:00 p.m., the resident's walker was within reach, and the resident had attempted to walk without assistance. Staff reviewed and updated the care plan, and 30 minute visual checks had been in place. Staff failed to update the care plan to include the increased visual checks to 15 minutes. No statements were obtained from any possible witnesses. A note on the form indicated, "Adding personal pull tab alarm to alert staff to aide resident."

Review of the resident's visual check log for

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7/28/13 revealed the first visual check of the day had been completed at 2:00 p.m., after the resident fell.

Review of a Nursing Progress Note dated 7/28/13 at 11:30 p.m. revealed the resident had no complaints voiced from fall. His/her left thumb had a bruise but the resident could move it.

Review of a Nursing Progress Note dated 7/30/13 at 9:00 a.m. revealed the resident ambulated with a walker and required the assistance of one staff member to go to the dining room for breakfast, had a stable/slow gait, and had been alert and confused. The resident's left thumb had edema (swelling), ecchymosis (bruising), pain with range of motion, and tenderness to palpation (touch).

Review of a Nursing Progress Note dated 7/30/13 at 3:00 p.m. revealed the resident went to the hospital for an X-ray of the left thumb and hand.

Review of a Nursing Progress Note dated 7/30/13 at 5:00 p.m. revealed that the nurse had been notified by hospital staff that the resident's X-ray showed a fracture of resident's left thumb. Staff took the resident to the hospital to be fitted for and outfitted with a left wrist splint.

Review of a Nursing Progress Note dated 8/1/13 at 12:44 p.m. revealed the resident had complained of left thumb pain, and the staff gave prn (as needed) Lortab (a narcotic pain medication) as ordered.

Review of a physician order form dated 8/2/13 revealed the resident suffered a non-displaced fracture to the left proximal phalanx (bones at the base of a toe or finger, the prominent, knobby ends of which are often called the knuckles) of

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the thumb and ordered a thumb spica (type of splint) splint full time except for when bathing, with follow-up in 4 weeks.

Review of the visual checks log for the resident from 6/10/13-8/15/13 revealed the failure of staff to consistently complete the logs, even though the care plan revised on 6/10/13 identified it as an intervention to prevent falls.

Observation on 8/12/13 at 2:01 p.m. revealed the resident sat with his/her eyes closed, in a recliner in his/her room with the foot rest up,and the call light and a pull alarm clipped to his/her clothing and left wrist splint in place.

Observation on 8/13/13 at 7:23 a.m. revealed the resident lay in bed with his/her eyes closed, the door to the resident's room open, and no call light within reach. All of the call lights in the room were looped over the call light box on the wall.

Observation on 8/13/13 at 7:47 a.m. revealed the resident lay in bed with his/her eyes closed with his/her knees bent and laying half off of the bed. The call light remained looped over the call light box on the wall and out of the resident's reach.

During an interview on 8/15/13 at 12:54 p.m. the resident reported he/she had fallen and injured his/her left hand (left thumb fracture). The resident reported it "hurt quite a bit" of the time.

Interview with the resident's family member on 8/19/13 at 8:10 a.m. revealed they had visited the resident several times and the resident frequently did not have a drink or call light within reach, and the tab alarm was not on. The family member reported the staff had started using the tab alarm after the fall when the resident broke his/her

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thumb.

Interview with direct care staff H on 8/13/13 at 3:50 p.m. revealed the resident was at high risk for falls, staff had the resident on 15 minute visual checks, and used a pull tab alarm. Staff H reported the resident did not know what his/her call light was for and played with it and that staff H thought the resident fell not too long ago, about 2 or 3 weeks ago, when the resident broke his/her thumb.

Interview with direct care staff J on 8/14/13 at 11:19 a.m. revealed the resident did have an increased fall risk, and interventions for a pull tab alarm, every 30 minute visual checks (identified a different time frame than direct care staff H), and to assist the resident with all ADLs (activities of daily living). Staff J reported the resident had not had any falls with major injuries, but a pull tab alarm and the visual checks had been recently implemented due to the resident's falls.

Interview with administrative nursing staff B on 8/13/13 at 9:57 a.m. revealed the resident had been wearing a pull tab alarm while in bed and he/she wore it all the time.

Interview with licensed nursing staff K on 8/14/13 at 9:26 a.m. revealed the physician usually wrote an order to make a resident a fall risk if a resident had an increased risk of falls, or if a resident became more unsteady on his/her feet, needed more assistance, had fallen, nursing staff made the resident a fall risk. Staff K reported if a resident fell, the nurse called administrative nursing staff A and B, and the physician, then they made suggestions about what to do or what new interventions to put in place. Staff K confirmed nursing staff could initiate fall

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F 323	Continued From page 81 interventions. Interview with licensed nursing staff K on 8/14/13 at 3:31 p.m. revealed if a resident fell, the nurse should do a head-to-toe assessment to determine any injuries, check vital signs, orientation, and level of consciousness, and try to determine why the resident fell. Staff K reported the charge nurse would then complete an incident investigation with witness statements and then notify the resident's family, physician, and administrative nursing staff A in as timely a manner as possible. Staff K reported staff would then initiate any new interventions depending on what the cause of the fall had been; maybe start visual checks, check to see if the environment needed to be changed, maybe a personal alarm. Staff K reported every time a resident fell, staff tried to implement a new intervention to prevent falls from happening again and then to let staff know about new interventions, the charge nurse updated the care plan and also in the 24-hour report book to reinforce the change. Staff K confirmed the resident fractured his/her thumb during his/her last fall and the resident now wore a brace to try and keep him/her from moving the thumb. Interview with administrative nursing staff A on 8/15/13 at 5:15 p.m. revealed he/she expected a fall investigation to include the cause of the fall, medications the resident took, add interventions to prevent further falls, if there may have been possible neglect by failure to follow interventions, and witness statements. Staff A confirmed for each fall, he/she expected there to be a new intervention added to the care plan. Staff A reported that after an incident report had been completed, it went to administrative nursing staff B, who reviewed it and then added any	F 323		

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interventions needed. Staff A reported he/she did not know why the tabs alarm did not get put in place sooner as mentioned in the fall investigations prior to the resident's injury and confirmed there could have been more interventions put in place to have prevented the resident from falling and breaking his/her thumb. Staff A confirmed the 30 minute visual checks had not been getting completed like they should have been and the charge nurses were responsible for ensuring they were completed.

Interview with physician O on 8/20/13 at 3:10 p.m. revealed the resident struggled with orthostatic hypotension (low blood pressure occurring in some people when they stand up) and the physician had a difficult time maintaining the resident's blood pressure as it tended to fluctuate quite greatly, and he/she believed it to be the main cause of the resident's falls, though the resident also had a decline in mental status. Physician O reported he/she saw the resident in the facility on 8/16/13 and did not know the resident had a fractured thumb as the facility staff had not brought it to his/her attention.

Review of the facility policy for Accidents and Incidents, last revised 2/1/05, revealed "The nurse supervisor/charge nurse and/or the department director or supervisor must conduct an immediate investigation of the accident or incident. b. The following data as it may apply, must be included on the Accident Investigation Report Form: 1. The date and time the accident or incident took place; 2. The nature of the injury/illness; 3. Where the accident or incident took place; 4. The injured person's account of the accident or incident if possible; 5. The time the injured person's attending physician was notified; 6. The date/time the injured person's family or

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F 323	Continued From page 83 DPOA (Durable Power of Attorney) was notified and by whom; 7. The disposition of the injured (...transferred to hospital, put to bed, sent home, returned to work,..); 8. Other pertinent data as necessary or required; and 9. The signature and title of the person completing the report. c. A completed Accident Investigation Report For must be submitted to the director of nursing services no later than twelve (12) hours after the occurrence of the accident." The facility failed to implement timely, appropriate and effective fall interventions for this cognitively impaired resident to prevent further falls, resulting in a broken thumb. - On 8/8/13 at 8:45 a.m., observation revealed an unlocked, unattended maintenance office on the north hall with Terro ant killer spray on a desktop with a warning that identified the chemical as hazardous to humans and animals. Also, a firebreak fire resistant sealer spray can sat on a low shelf just inside the door that contained a warning to keep out of reach of children. Direct care staff C and D confirmed the door was unlocked at the time and usually unlocked when staff were present, but it got locked at night. Staff C reported he/she did not think the door needed to be locked. Staff C confirmed the ant killer spray and sealer spray were available to residents and should not be. On 8/8/13 at 8:52 a.m., observation revealed an unlocked, unattended north public bathroom with Lysol disinfectant aerosol spray also with a warning to keep out of reach of children The key to the bathroom door lay on a cabinet inside. Interview on 8/8/13 at 8:55 a.m. with administrative nursing staff B confirmed the door should be locked.	F 323		

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F 323	Continued From page 84 Observation on 8/8/13 at 8:10 a.m. revealed the north hall shower room was unlocked and unattended. There were 4 jugs of Whirlbath lemon clean liquid in an unlocked cabinet with a warning to keep out of reach of children. Also, a spray can of Lysol sat in unlocked open cabinet with a warning to keep out of reach of children and a bottle of Comet spray cleaner with bleach hung in shower. Interview with administrative nursing staff A on 8/15/13 at 5:15 p.m. revealed chemicals should be stored as recommended by the MSDS (Material Safety Data Sheet) and confirmed the residents should not have access to the chemicals. Staff A confirmed chemicals should be behind lock and key. Review of the facility's policy for Storage Areas, with no revision date, revealed, "Cleaning supplies ... shall be stored as instructed on the labels of such products." The facility failed to store chemicals in a manner to prevent accidents to the cognitively impaired, independently mobile residents. - Review of resident #26's physician's orders sheet signed 7/12/13 revealed the resident with diagnoses of hemiplegia (paralysis of one side of the body) affecting non-dominant side, cerebral artery occlusion with infarction (blockage of an artery in the brain that resulted in a stroke), and edema. Review of the resident's Admission MDS (Minimum Data Set-a required assessment) dated 4/26/13 identified the resident with a BIMS (Brief Interview for Mental Status) score of 3	F 323		

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(indicated severely impaired cognition), required limited assistance from 1 staff for bed mobility, transfers, walking in room, supervision of one for walking in the corridor, and locomotion on the unit only occurred once or twice with one person assist. The assessment identified the resident had no fall any time in last six months prior to admission, or since admission into the facility.

Review of the resident's Quarterly MDS assessment dated 7/27/13 revealed the resident had a BIMS of 6 (indicated severely impaired cognition), no changes in ADL (Activities of Daily Living), and had experienced 2 or more falls with injury (except major injury) since prior assessment.

Review of the Fall CAA (Care Area Assessment) for the 4/26/13 MDS revealed, "Resident ambulates with walker and is not always steady. Has been ambulating without direct assist at this time. Does use a walker." "Family aware of resident's lack of steadiness. Would like him/her to continue to ambulate as able." "Care plan will focus on resident maintaining his/her current ability to ambulate with walker and no stand by assist."

Review of the resident's care plan dated 5/14/13 revealed the resident was at high risk for falls related to a history of falls and directed staff to be sure to place the call light within reach of the resident and encourage to use for assistance as needed, have a fall mat next to the bed at night to reduce injury should the resident fall from bed, have a pull tab alarm attached to the resident to alert staff when up, identified the resident needed a safe environment with even floors free from spills and/or clutter, adequate, glare free light, a working and reachable call light, bed in low

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position at night, handrails on walls, and personal items within reach, required one person assist for ambulation and toileting, used a pressure sensor that was attached to the call light system, ensure device is in place as needed, please check on the resident every 15 minutes to ensure the resident did not try to get up without help.

Review of the resident's Resident Incident Investigations revealed the following:

On 5/15/13 at 9:45 p.m. the resident had a fall - "Heard resident holler 'help'. Into residents room and observed resident on floor. Res (resident) stated he/she was trying to go to the restroom and states he/she hit his/her head. Resident was laying on right side. Hematoma (bump) to right side of head and scratch to middle of back with bruising. Called on-call doctor gave order to send to ER (emergency room). Notified DPOA (Durable Power of Attorney)." On the form, staff circled "Go to the bathroom" and documented "attempting to go to restroom." The staff failed to document if the previous interventions of visual checks, call light within reach, bed (not high or low), or fall mat beside bed had been in place. The assessment identified staff sent the resident to the ER.

On 6/9/13 at 1:55 p.m. the resident had an un-witnessed fall - "This nurse was called to resident's room and observed the resident on the floor. Alarm was attached to resident. CNA (Certified Nurse Aide) states that resident had just turned his/her light on and CNA was going to room to answer call light and states before staff got to the room he/she observed the resident on the floor. Resident denies hitting head. Neuro (neurological-having to do with brain function) checks in place. Resident complains of side pain

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on right side. PRN (as needed) Tylenol given. No other injuries noted at this time. (Did not identify if alarm was sounding). Identified "the resident was attempting to walk, and to go to the bathroom. Did not indicate when was last toileted " Time last toileted" blank. 15-minute visual checks initiated (added to care plan 6/10/13), bed/chair alarm in place but did not indicate if was sounding, call light within reach, and cognitive to use appropriately, bed in between (not high or low). Skin tear to right forearm. "Needing frequent toileting" on diuretic. Statement from staff "I was walking to the resident's room to answer a call light. He/she had rang several times because his/her hearing aid kept falling out. As I was heading there I heard him/her pull alarm go off so I ran to his/her room and found him/her on the floor by his/her bed. I yelled that I needed the nurse and I waited with him/her while the nurse did the assessment. He/she did not complain of any pain or soreness."

Review of the Physician order form dated 6/17/13 revealed "...Ambulate only with assist, bed alarm. Low bed, fall precautions. Soft mat by bed."

On 7/22/13 at 04:05 a.m., the resident had an un-witnessed fall with injury - "Heard resident call out for help when CNA (Certified Nurse Aide) answered the call staff found resident lying on the floor on his/her right side. Resident stated he/she wanted to go to the bathroom by himself/herself and when he/she went to sit down on bedside commode it tipped and caused him/her to lose his/her balance causing him/her to fall, resulting in a skin tear to his/her right elbow, 2 cm (centimeters) in in size. Staff applied steri strips (type of dressing) and gauze. Bed alarm was on and call light was attached to resident prior to fall. ROM (Range of Motion) performed - no

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complaints voiced of any discomfort from fall. Identified a transfer, last toileted at 03:00 a.m. 'He/she was wanting to start doing more for himself/herself". Body alarm care planned, but body alarm sounding not marked, bed/chair alarm in place, 30 minute visual checks (time of visual checks prior to fall), call light in reach prior to fall, cognitive to use appropriately, skin tear obtained. "Resident has 30 minute visual-checks (inaccurate-care plan identified 15 minutes checks), personal alarm. Will encourage res to use call light. Bed in low position." Confidential Interview form "I found resident on the floor in his/her room with his/her commode on top of him/her. He/she called out 'help me' so I went down to see what he/she needed. He/she said he/she thought he/she could get up himself/herself."

On 7/27/13 at 9:50 p.m. the resident had a fall - "Resident was found sitting in front of his/her bedside commode by CNA (Certified Nurse Aide). Resident stated he/she was going to go to the bathroom and missed the commode. ROM (Range of Motion) performed and resident was placed on commode. No complaints other than his/her back and he/she said it was hurting prior to incident." Attempting to go to bathroom "he/she thought he/she could do it himself/herself" Body alarm care planned, on 30 minute visual checks (inaccurate-care plan identified 15 minute checks), bed/chair alarm in place, but did not identify if "Body Alarm sounding" call light within reach, and cognitive to use appropriately at times. Bed in low position. Resident in unsupervised area. It identified staff did not update the care plan but reviewed the care plan without developing changes. Last time toileted was blank. "Resident wants to do more for himself/herself. If there is an alarm on him/her, he/she takes it off

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sometimes. Need to place alarm further back and have a bed alarm on while in bed. Encourage resident to use call light. Already on visual checks." No staff interviews noted.

Review of the "15 Minute" checks for the resident from 8/7/13-8/14/13 revealed staff failed to document multiple times, resulting in hours where the documentation revealed staff failed to check on the resident every 15 minutes as planned.

Observation at 8:15 A.M. on 8/13/13 revealed the resident sat in a recliner with his/her feet elevated, covered with a blanket, call light within reach and a tab alarm attached to the back of the resident's shirt.

On 8/13/13 at 10:02 A.M. observation revealed Direct care staff C applied a gait belt and assisted the resident to ambulate the bathroom. Staff C reported he/she checked on the resident every 2 hours. Staff C helped the resident to stand and walk back to the resident's chair. Resident turned and started to sit too early, staff C cued the resident to turn more. At 10:10 A.M., staff C left the room and failed to reapply the string on the pull tab alarm to the resident. At 10:20 A.M. no one re-entered the room to apply the pull tab alarm.

Observation at 10:33 A.M. on 8/13/13 Medical Records staff R walked down the hall, delivering mail. Staff R looked into the resident's room, but did not go into the resident's room or fix the pull alarm.

Observation at 10:37 A.M. on 8/13/13 revealed Social Services S walked down, then up hall past room without fixing the resident's pull cord.

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Observation at 10:46 A.M. on 8/13/13 revealed Dietary Manager M walked past room twice and failed to reattach the pull alarm.

At 11:01 A.M., Direct care staff C walked into the resident's room for just a moment then turned around and walked out. Staff C failed to apply the alarm to the resident.

Observation on 8/13/13 at 11:03 a.m. revealed direct care staff C again went into the resident's room, this time to assist the resident to the bathroom. Another resident occupied the bathroom at that time, so staff C waited. At 11:04 a.m., staff C put a gait belt on the resident, assisted the resident to stand, and then walked with the resident to the bathroom. The resident had not had a personal alarm in place. The resident went to the bathroom, then staff C assisted the resident back to his/her chair, put the resident's call light in his/her lap, raised the resident's foot rest, and left the room. Staff C did not clip the string on the personal alarm onto the resident before leaving the room. Staff C returned to the room at 11:13 p.m. and filled the resident's water pitcher and did not put the resident's personal alarm in place.

Observation at 11:23 A.M. on 8/13/13 revealed Administrative Nurse B walked down hallway, looked in resident room, and without stopping to attach the alarm, continued to walk down hallway.

On 8/13/13 at 11:37 A.M. Direct care staff C stated he/she remembered putting the alarm on the resident "the last time." Staff C reported resident took it off at times. Immediately after visiting with the staff, observation of the resident revealed he/she sat in a recliner in his/her room, with the foot rest elevated. The string on the

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personal alarm remained connected to the alarm on the chair. The end of the string (intended to be attached to the resident) hung down the chair, not attached to the resident, but connected by a magnet to the alarm.

Observation at 11:25 A.M. on 8/15/13 in resident's room revealed Activity staff I, who also worked as a direct care staff at times, reported he/she had not seen any floor mat next to the resident's bed or in the room, and reported maybe the mat addressed in the care plan was the pressure alarm mat used when the resident laid in bed. Staff I was able to point out the pressure alarm pad on the bed, but reported there was no other mat in the resident's room.

On 8/14/13 at 3:16 P.M., Direct care staff G stated the resident had a bed alarm and personal pull alarm, and staff applied both even when the resident laid in bed. Staff G stated staff were to clip the call light onto the resident's shirt. Staff G did not think the resident had a floor mat and reported the resident used the call light. Staff G said he/she knows when he/she needs to go to the bathroom, but stated the resident would ring and tell the staff a lot of times it would be too late. Staff G identified the resident's toileting program including assisting the resident to the toilet every 2 hours. When in the recliner in his/her room, staff are to ensure the resident had the alarm on, but there was nothing else really the staff do. Staff G then remembered the resident was on 30 minute checks, and reported that staff went into the resident's room and made sure the resident's pull tab was on, offer the resident a drink of water, or see if he/she needed to go to the bathroom.

On 8/14/13 at 11:01 A.M., Direct care staff Q

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stated the facility had the expectations of the direct care staff charted in the computer system-it would be on care plans. Staff Q identified the resident was a Fall Risk. The interventions included lower bed to floor; he/she had a bed alarm and a pull tab alarm. Staff Q reported staff moved the walker out of the reach of the resident so that way he/she is not tempted, placed the call light within reach. Staff Q reported no floor mat on the floor that he/she had noticed. "I cannot ever remember a floor mat." Staff Q identified the resident had a fall recently, but did not quite remember when or what staff did differently afterwards-staff Q has not noticed any changes in care. Staff Q stated the resident should have the pull tab alarm on when the resident sat in the recliner or in wheelchair or in the dining room. If it is positioned just right, he/she will reach around and take it off, but staff Q stated the resident has not done that lately. It had been a week or two since the resident took the alarm off. Staff Q said the resident used the pressure alarm only in when the resident laid in bed. Staff Q said he/she checked the resident when he/she went down the hall; he/she would peek in and see how the resident was doing. Staff Q then stated the resident was on 15 or 30 minute checks, too (but did not remember which specifically). Staff Q identified anyone who came in contact with the resident had the ability to check the alarm to make sure it was attached, or offer the resident a drink of water. Staff Q identified a book up at the front by the nurse's station that had it in there.

On 8/14/13 at 1230 P.M. Licensed nursing staff K reported the resident had a tab alarm placed by staff whenever the resident sat in a chair, and also used a bed alarm and the staff never let him/her up by himself/herself. Staff K reported in 3 months' time, the resident declined from

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ambulating independently to the dining room to a very big fall risk. Staff K stated he/she was not sure what was going on with the resident, the staff were trying to figure it out. Nurse K reported any time the resident sat in the recliner; staff were to ensure the resident had the tab alarm on. Nurse K provided the documentation book where staff were to document that they checked on the resident every 30 minutes. Nurse K confirmed the staff failed to document completion of a lot of the 30 minute checks. Nurse K stated that staff were to document a check mark and the time. The check mark meant staff walked by, saw location of, laid eyes on the resident, saw tab alarm on, or appeared comfortable. Nurse K agreed the charge nurse was responsible for making sure the staff completed the documentation.

On 8/15/13 at 3:49 P.M. Administrative Nurse A reported the 30 minutes checks were for making sure the resident had not fallen, making sure the resident either sat in the chair or was in bed. Then the staff modified a few of the checks with special interventions. Staff A confirmed part of the check, staff were to make sure the resident's pull tab alarm was on and documenting their initial that it was completed. Nurse A identified that care plans should include fall interventions. Staff A reported the nurses were responsible for making sure staff completed the 30 minute checks. At 5:20 P.M. the same day, Nurse A identified that if the resident had an un-witnessed fall, then the investigation needed a witness statement from the person who found them. Staff A reported having trouble with incident reports and planned to do an in-service. Staff A confirmed the falls needed a thorough investigation and the care plan interventions were made as a result of the investigation.

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F 323	Continued From page 94 During an interview with Administrative Nurse B at 5:50 P.M. on 8/15/13, Nurse B reported the resident should have a mat on the floor in his/her room because it was an order from the physician. Administrative Nurse B went into the resident's room and found the mat in the resident's closet folded up. The facility failed to thoroughly investigate all falls to determine causal factors and failed to implement all interventions to prevent falls, including using a floor mat while in bed and the use of a pull tab alarm while seated in a recliner for this cognitively impaired resident.	F 323		
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This Requirement is not met as evidenced by: The facility census totaled 25 residents with 18 included in the sample. Four residents were sampled for nutrition. Based on interview, observation, and record review, the facility failed to identify and provide interventions for severe weight loss in 2 of 4 residents reviewed for nutrition (#34, #8). Resident #34 lost 39.4 pounds from 6/4/13 until 7/29/13, or 18% of	F 325		

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his/her weight. Resident #8 lost 8.2 pounds from 6/25/13 until 7/29/13, for a 6.1% weight loss.

Findings included:

- Review of resident #34's signed physician orders dated 8/10/13 revealed the following diagnoses: azotemia, chronic orthostatic hypotension, hypotension, vascular dementia, and weakness. The resident had been admitted to the facility on 4/23/13.

Review of the admission MDS (minimum data set) dated 5/2/13 revealed a BIMS (brief interview for mental status) score of 2, indicating severe cognitive impairment. The resident had minimal hearing loss, wore hearing aids, usually made him/herself understood, understood others, and had adequate vision. The resident required setup assistance for transfers, was independent with setup assistance for toileting, and required supervision with setup assistance for walking in the room and corridor and eating. The resident did not have any special dietary considerations and no identified significant weight loss. The resident did not have teeth, but did not have problems with his/her dentures.

Review of the quarterly MDS dated 8/2/13 revealed a BIMS had not been completed. The resident had problems with short and long term memory recall, continuously had inattention, had moderately impaired decision making, and continuously had disorganized thinking. The resident had highly impaired hearing, wore hearing aids, impaired vision, wore glasses, usually made him/herself understood, and understood others. The resident required extensive assistance of one person for transfers, walking in the room and corridor, dressing,

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eating, and toileting. The resident had trouble with residual food in his/her mouth after eating, loss of fluids/solids from his/her mouth while eating or drinking, no difficulty swallowing, weight Loss of 5% or more in the last month or loss of 10% or more in last 6 months, and not on a planned weight loss program. The resident did not receive any special nutritional approaches. The resident did not have any dental issues, including broken or loosely fitting full or partial dentures (chipped, cracked, uncleanable, or loose).

Review of the Cognitive Loss/Dementia CAA (care area assessments) dated 5/7/13 revealed an analysis of findings of: "Resident very confused and has more difficulty during late afternoon and evening." No further information had been included.

Review of the Nutrition CAA dated 5/7/13 revealed "Resident eats well, potential for weight gain." No further information had been included.

Review of the Dental CAA dated 5/7/13 revealed, "Resident has upper and lower dentures." No further information had been included.

Review of a Nutritional Risk Assessment dated 4/26/13 revealed the resident had a moderate risk for nutritional impairment.

Review of a Nutritional Risk Assessment dated 5/8/13 revealed the resident had a moderate risk for nutritional impairment.

No further Nutritional Risk Assessments had been completed.

Review of the resident's care plan for unexpected weight loss/poor nutrition with a date of revision of

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F 325	Continued From page 97 8/8/13 revealed interventions that directed staff to encourage the resident to eat and drink fluids, weigh the resident weekly until his/her weight was stable, notify the resident's physician and DPOA for any significant weight loss or gain, provide Boost nutritional supplement drinks three times a day (added 8/11/13), offer substitutes as requested or indicated (prefers breakfast foods and soft things), give the resident supplements as ordered, alert nurse/dietitian if not consuming the supplements on a routine basis, and monitor and record food intake at each meal. Review of the resident's care plan for dental health dated 8/6/13 revealed one intervention that directed staff to provide mouth care for personal hygiene. The care plan lacked any mention of dentures, denture care, or that the resident had thrown his/her dentures away. Review of a Dietary Progress Note written by the dietary manager on 5/14/13 at 12:49 p.m. revealed "Resident is adjusting to facility, appetite is good, comes to dining room for meals, family comes and eats with him/her often. Albumin within normal limits. Diet is regular with texture as tolerated." Review of a Nursing Progress Note dated 6/6/13 revealed a family member had eaten breakfast with the resident and the resident stated "I threw my damned teeth away; they were not worth a shit." Nursing staff notified the social services director (SSD) and an appointment was made with the dentist for July 16th. Review of a Nursing Progress Note dated 6/23/13 revealed the resident had been up for the noon meal. "Observed res [resident] having increase difficulty with eating task. Holding food in [gender] mouth."	F 325		

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F 325	Continued From page 98 Review of a physician order form dated 7/16/13 revealed the resident had been to the dentist for an impression for upper and lower dentures. Review of a physician order form dated 7/24/13 revealed the resident had been to the dentist for a wax try in and bite registration for denture fitting and the next appointment time for 8/14/13 at 2:30 p.m. Review of a Dietary Progress Note written by the dietary manager on 7/24/13 at 11:28 p.m. revealed the resident "sits at assisted bar in dining room and is not eating well. [Gender] sits and stacks [gender] food and then pours [gender] drinks all over the food ... stacked and then proceeds to clean up the mess. When you cue [gender] to eat, [gender] is pocketing the food ... in [gender] mouth and then when you tell [gender] to chew it and swallow it, [gender] will either scoop it out ... and give it to you or ... simply spit it out ... Nursing is aware of this." Review of a Dietary Progress Note written by the dietary manager on 8/6/13 at 1:57 p.m. revealed the resident "comes to dining room for meals. Sits at assisted bar unless family is here to sit with him/her. He/she is not eating well, plays in foods and spends most of meal time wiping down the counter over and over until leaving dining room." Review of the resident's dietary progress notes from 4/23/13- 8/15/13 revealed the dietician had not made a progress note. A fax to the physician on 7/2/13 notified the physician the resident had weight loss and the resident had been moved to the bar in the dining room to receive assistance.	F 325		

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A fax to the physician on 7/2/13 revealed the resident had been taking Seroquel and had been losing weight and sleeping more. The nurse asked for a decrease in the medication, and the physician agreed.

Review of a fax signed by the physician on 7/5/13 revealed the resident had a weight of 178.8 lbs. on 7/2/13 which the fax indicated was a -14.5% 30.4 lb. change over 30 days and an 11.1% 22.4 lb. change over 90 days. The physician replied, "Weight loss not unreasonable in light of pt's [patient's] deteriorated mental status. Continue to monitor."

Review of a fax signed by the physician on 7/26/13 revealed the resident had a weight of 172.2 lbs. on 7/22/13 which the fax indicated was a -5.7% 10.4 lb. change over 30 days and a 14.4% 29.0 lb. change over 90 days. The physician replied, "Weight loss noted. Continue to monitor."

Review of the physician signed order summary report dated 7/19/13 revealed the resident had a regular diet ordered with as tolerated texture and thin consistency.

Review of the resident's weights revealed:
4/30/13 at 201.2 lbs. (pounds)
5/6/13 at 199.6 lbs.
5/13/13 at 203.2 lbs.
5/20/13 at 202 lbs.
5/27/13 at 208.8 lbs.
6/4/13 at 209.2 lbs.
6/10/13 at 203.6 lbs.
6/24/13 at 182.6 lbs.
7/2/13 at 178.8 lbs.
7/8/13 at 178 lbs.

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F 325	Continued From page 100 7/15/13 at 177.4 lbs. 7/22/13 at 172.2 lbs. 7/29/13 at 169.8 lbs. 8/6/13 at 169.8 lbs. 8/10/13 at 180.8 lbs. 8/12/13 at 178.2 lbs. Observation on 8/15/13 at 3:14 p.m. revealed direct care staff H weighed the resident to be 181.0 lbs. The weight loss between 4/30/13 and 8/15/13 totaled 20.2 lbs. or 9.9% in 3 1/2 months, indicating severe loss. Review of the May, June, and July 2013 MARs (medication administration record) revealed the resident had not received health shakes or any other dietary supplementation. Review of a Social Services Progress Note dated 8/8/13 revealed the resident's family member spoke with the SSD about the resident's diet and care. The family member had voiced concerns about the resident's diet, lack of assistance in the dining room, not sitting at the "feeders table," and weight loss. SSD reported to the family member that the aides had been sitting the resident at the "feeders table" and were needing to cue him/her more. The family member discussed the need for the resident to eat more vegetables and fruit for nutrition, and not "so much junk". The family member requested a daily supplemental drink, such as Ensure. SSD advised the family member that the resident had been having a hard time eating due to not having his/her teeth and the increase in dementia. and that staff were "not allowed to force feed resident." SSD assured the family member that he/she would speak with dietary staff M about the resident's diet, possibly	F 325		

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changing it to pureed or ground and also to nursing about starting supplemental shakes.

Review of a physician order dated 8/11/13 revealed an order for Ensure or a supplement shake three times a day, encourage the resident to make food choices, and encourage fluids by mouth.

Observation on 8/13/13 at 9:53 a.m. revealed the resident drank a serving of Boost Breeze (240 calorie per serving supplement).

Observation on 8//13/13 at 10:29 a.m. revealed the resident fed him/herself a waffle with syrup, a honey bun, and a serving of ground sausage, and drank a half a cup of coffee, a large glass of grape juice, and a glass of ice water. The resident ate and drank 100% of everything. Administrative nursing staff B offered the resident more to eat and he/she declined.

Observation on 8/13/13 at 12:30 p.m. revealed the resident sat in the dining room and fed him/herself shredded pork, cottage cheese, cake, strawberries, and drank a Boost Breeze and a large glass of water.

Observation on 8/14/13 at 3:42 p.m. revealed the resident had just returned from the dentist with new dentures in place.

Interview with the resident's family member on 8/19/13 at 8:10 a.m. revealed the resident had lost about 30 lbs. The family member reported that there had been several discussions with the facility about the resident's weight loss, and the facility seemed shocked that the family had so much concern. The family member reported the facility had lost the resident's dentures the first

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week he/she had lived in the facility, so that had made it difficult for the resident to chew. The family member reported the facility had been feeding the resident food that he/she could not chew and "we told the staff that they were starving [gender] to death." The family member reported that administrative nursing staff A's response to a lot of the concerns had been, "They just don't train the CNAs [certified nurse aides] like they used to."

Interview with direct care staff H on 8/13/13 at 3:50 p.m. revealed the resident had a poor appetite at supper usually, but otherwise ate well. Staff H reported that staff had been talking about changing the resident's diet to pureed to see if he/she ate better, and if the resident did not eat, staff offered the resident snacks when completing visual checks. Staff H reported that the dining aide or the CNAs always charted the resident's percentage of intake at the meals, but it varied as to who charted it. Staff H reported the CNAs knew that if it had been done, it showed up green in the resident's computer chart at the end of the shift and usually, the staff just knew who to keep an eye on for charting meal intake, or asked the dining aide to chart it before he/she left.

Interview with direct care staff J on 8/14/13 at 11:19 a.m. revealed the resident had lost weight, had thrown his/her dentures away, had been to the dentist, and his/her new dentures should be here soon. Staff J reported the resident received health shakes and Boost drinks to help prevent further weight loss.

Interview with licensed nursing staff K on 8/14/13 at 3:31 p.m. revealed the resident needed prompting to eat during meals, and when the resident threw his/her dentures away, staff had

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started the resident on a pureed diet and that helped with his/her intake. Staff K reported the resident had lost weight and had recently been started on health shake supplements. Staff K reported the resident had a significant weight loss of about 20 lbs. of weight loss in about 4 months.

Interview with administrative nursing staff A on 8/15/13 at 5:15 p.m. revealed weight loss had been discussed during the care plan meetings. Staff A reported staff had been giving nutritional supplements, but it had not been documented and staff A thought the dietary staff had been documenting the supplements given during meals, but they were not. Staff A did not know if there had been a person designated to identify weight loss. Staff A reported that as soon as weight loss had been identified, staff should move the resident to the assisted feeding table, offer nutritional supplements, ask the physician for an order for appetite stimulants, and try to figure out why the resident had lost weight or continued to lose weight Staff A reported that if they had tried all of those things and the resident still lost weight, staff should ask for physician documentation as to the cause of the weight loss. Staff A confirmed the resident had some weight loss, had been moved to the assisted feeding table, got new dentures, and staff had given the resident some shakes that had not been documented. Staff A reported the resident had been eating better and would have expected interventions to be in place much sooner to prevent further weight loss.

Interview with dietary staff M on 8/15/13 at 2:11 p.m. revealed the resident had lost about 30 pounds and the resident's family had given the dietary staff a list of things the resident would not eat, but sometimes he/she would eat them. Staff

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M reported staff would put extra sugar in the resident's super cereal [nutritionally fortified cereal], and added sweetener to the resident's juice. Staff M reported staff had to sit with the resident when he/she ate or drank to remind the resident to eat. Staff M confirmed Boost had just been started that week, but staff had been offering it to the resident experimentally before then and confirmed it had not been documented anywhere. Staff M identified the resident as "way above" his/her ideal body weight, so "we didn't really see a concern." Staff M reported that when the resident started eating less, staff started really trying to figure out why the resident had started losing so much weight and staff M thought the dietician was aware of the resident's weight loss and would have made a note in the computer if he/she had seen the resident. Staff M reported it his/her responsibility to identify weight loss, notify the dietician, and notify the physician if needed, and would expect 5% weight loss in 30 days to be reported to the physician and at that point, something needed to be done. Staff M reported that if a resident did not eat their whole meal, sometimes, staff offered them a shake.

Interview on 8/20/13 at 1:49 p.m. with consultant staff N revealed he/she had not been notified of the resident's weight loss and expected to be notified as soon as staff identified weight loss. Staff N reported that he/she made monthly visits to the facility reviewed a referral list from the dietary staff M, talked with staff M and administrative nursing staff A to identify issues, if needed discussed concerns with family members and health care providers, and occasionally attended care plan meetings. Staff N reported his/her definitions of significant weight loss were concurrent with the state regulations and if a resident had significant weight loss, depending on

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the resident's diagnosis and ability to eat, staff N would make recommendations for dietary supplements, increasing food intake, diet changes, and talk with the provider among other things to develop an individualized plan for the resident to prevent any further weight loss.

During an interview on 8/20/13 at 3:10 p.m., physician O reported he/she knew of the resident's significant weight loss and the resident had a spell where he/she had not been eating well, actually losing between "40-50 lbs. in the last several months". Physician O confirmed that amount of weight loss was "a lot of weight in a hurry" and he/she believed it to be of dietary cause from poor nutrition, but it had some benefit as the resident had been "quite portly" before. Physician O reported he/she did not think dietary supplements had been ordered yet.

Review of the facility policy for Interdepartmental Notifications of Diet (Including Changes and Reports) revealed, "Nursing services shall notify the physician and the clinical dietician when a nutritional problem (... weight loss, pressure ulcer, eating problems...) has been identified and shall collaborate with the dietician and physician to initiate an appropriated process of clinical review for causes of the nutritional problem."

The facility failed to implement interventions to prevent severe weight loss for resident #34.

- Review of resident's #8 electronic Order Summary Report, signed by the physician on 7/29/13 revealed it identified the resident with the following diagnoses: senile dementia (progressive mental disorder characterized by failing memory, confusion), vascular dementia with deperssed mood (abnormal emotional state characterized by

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exaggerated feelings of sadness, worthlessness and emptiness), hyperlipidemia (condition of elevated blood lipid levels), dysphagia (difficulty in swallowing), and anemia (a condition without enough healthy red blood cells to carry adequate oxygen to body tissues.

Review of the resident's annual MDS (Minimum Data Set-a required assessment) dated 10/31/12 revealed it identified the resident with a BIMS (Brief Interview for Mental Status) score of 15 (indicative of little to no cognitive impairment). The assessmnet identified the resident required supervision and set-up assistance with eating, had no swallowing problems, a steady weight of 142 pounds, and did not receive a therapeutic or mechanically altered diet.

Review of the resident's quarterly MDS assessment dated 8/2/13 revealed it identified the resident with a BIMS of 15, needed supervision and set up assistance with eating, had no loss of liquids or solids from mouth when eating or drinking, holding food in mouth, couging or choking, or complaints of difficulty or pain when swallowing. It identified the resident had experienced a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months, a weight of 125 pounds, and did not receive a therapeutic or mechanically altered diet.

Review of the Nutritional Status CAA (Care Area Assessment) for the 10/31/12 MDS assessment revealed staff failed to complete the assessment.

Review of a Nutrition Progress note completed with a plan of care revision and dated 11/6/12 identified the resident's usual body weight as 131.4 pounds, the resident had a good appetite, received a regular diet with a texture as tolerated,

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a current weight of 142.2 pounds. The note identified the resident's weight was above the resident's ideal body weight of 110 pounds, the resident ate approximately 100% of meals and had no concerns or changes at that time.

Review of the care plan revealed it lacked anything regarding weight loss. Review of the resident's Care Plan Conference Sumary dated 2/5/13 identified staff documented "the resident came to dining room for meals- appetite good."

Review of Nutritional Risk Assessment dated 5/8/13 revealed it identified the resident had "no weight change", intake met 76-100% of the resident's dietary needs. The assessment also identified the resident as ambulatory, alert, able to feed self, no chewing or swallowing problems, albumin (a blood test used to measure the amount of protein in the blood and is used in part to determine a person ' s nutritional status) and other nutrition-related lab values WNL (within normal limits), and intact skin.

Review of an Admit/Readmit Assessment dated 6/25/13 revealed the resident had no teeth, full upper and full lower denture, noted dentures fit, then "if not, worn only when eating." It identified no chewing or swallowing problem, no pain. The assessment also identified the resident had a weight of 133.4 pounds.

Review of the physician's orders sheet, signed on 7/29/13 revealed on 6/13/13 the physician gave the staff an order for healthshakes. The order lacked instructions on frequency or indication for use.

Review of the resident's weights revealed the following:

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F 325	Continued From page 108 6/25/13--133.4 pounds 7/2/13--130.2 7/8/13--131.4 7/15/13--128.2 7/22/13--128 7/29/13--125.2 Review of the MAR (Medication Administration Record) for August 2013 revealed "Health Shakes". All days with an "x" in the box-no initials. Review of a Nutritional Risk Assessment dated 8/5/13 identified the resident had no weight change, the resident's intake met 76-100% of the dietary intake needs. It further identified teh resident as ambulatory, alert, able to feed self, no chewing or swallowing problems, Albumin 30-34 g/L (grams per liter), and 1-2 other nutrition related labs abnormal (but failed to identify which ones). Review of a care plan note by Dietary staff M and dated 8/6/2013 identified the resident no longer came out to the dining room for meals as often as used to- not eating well- takes a bite or two and then states that he/she feels ill. Weight is down 17.2# in last 6 months. Nursing aware of lower appetite and weight change. Observation at 2:09 P.M. on 8/12/13 revealed snacks on a rolling drawer cart next to the resident's bed and bed side table. Observation at 10:29 A.M. on 8/13/13, revealed the resident rested in bed. reported he/she ate two 1/2 triangles of toast, and drank most of his/her tea. The resident reported he/she just did not feel well, and was not hungry. Observation at 12:10 P.M. on 8/13/13 revealed	F 325		

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staff entered the resident's room and provided the resident with a room tray of green beans, spotted cake, macaroni and cheese and pork. Direct care staff C reported they thought the resident had maybe experienced some weight loss. Staff C thought it was due to difficulty with swallowing but not related to teeth. Staff C remembered the resident used to get milkshakes and milk and other kinds of things, but thought that made him/her sick. Staff C identified the resident did not like a lot of milk, and reported he/she thought the food was good, and the resident got enough of it. Observation at 12:40 P.M. revealed the resident ate 25% of the cake, ate between 25-50% of meat and sides. The resident reported it was all delicious and the meat tender, but did not want anymore.

Observation at 2:35 P.M. on 8/15/13 revealed Direct care staff H assisted the resident to therapy room to weigh the resident. The residents weight totaled 123.4 pounds.

Direct care staff Q at 11:01 A.M. on 8/14/13 reported he/she could not tell if the resident had weight loss or not. Staff Q identified that he/she weighed everyone every Monday. Staff Q did not know of any supplements or special snacks that the resident recieved, no specialized diet at meals. Staff Q said the resident had upper dentures and their own teeth on bottom. Top ones are only ones that staff Q had seen or cleaned for him/her. Staff Q said the resident has not ever complained about his/her mouth or teeth, if he/she did staff Q would report it to the nurse and they could come check it out. The resident does oral care for himself/herself, he/she can set it up all on his/her own.

During an interview at 255 P.M. on 8/15/13, Direct

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Care staff H reported did not know if the resident had any weight loss. Reported did not ever give the resident shakes, did not know if the resident ever needed or received shakes, but thought the medication aide or kitchen staff provided them.

Licensed Nurse K at 12:53 P.M. on 8/14/13 reported the resident had been really sick a couple months ago-had major GI (gastrointestinal) bleed. Nurse K thought the resident had done real well, when asked about weight loss, reported thought the resident might have actually gained a little bit back. Administrative Nurse B would let know the nursing staff know if the resident had lost weight. Nurse K reported he/she had not been notified of the resident's 10 pound loss since 6/25/13 and stated "this surprises me." Nurse K identified Direct care staff Q weighed the residents every week on Monday, then entered the weights into the computer. Administrative Nurse B is responsible for identifying loss notifying physician.

During an interview at 1:11 P.M. with Administrative Nurse B on 8/15/13 revealed the facility's program was computerized and identified if they have had weight loss or gain. When a resident has lost 5% I notify the physician. Administrative Nurse B stated he/she faxed the physicians a sheet that has what the weight loss is, documentation that includes what the residents are eating, supplements they get, and the physicians review the fax and sign. If they want to add any new orders, they will do that, then the staff put the fax in the chart. Nurse B identified Consultant N came in monthly. Nurse B stated he/she believed the resident had a weight loss. Reported to the physician on 8/6/13 that the resident had a weight loss of 17.2 lbs in the last 6 months. New interventions include staff to

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encourage the resident to eat-this is a big one. Staff are to offer him/her supplements. The resident just does not want to eat. Nurse B stated he/she did not know what the doctor's response was to the weight loss. Nurse B reported he/she did not think staff documented anywhere whether staff offered a supplement or if the resident consumed a supplement. Nurse B stated he/she did not know if the supplement was effective since he/she did not if the resident had been taking them or not. Then walked up to the front desk and showed a 7/24/13 Physician communication Note - Weight warning value 128 lbs -7.5% change over 90 days Signed - Response from physician revealed no change in care plan. Administrative Nurse B reported did not know why they wrote no change in care plan. Dietary staff M looks at them as well. Nurse B did not know how often dietary staff M looked at the weights, but knows he/she has the capability. Thinks at least looks at them at care plans. Nurse B stated he/she did not notify dietary staff M or the consultant N of weight changes. Not sure if dietary staff M notifies consultant N. Administrative Nurse B stated I have orders on everybody, but typically I will not make a nutrition care plan unless they need one. Did not see one related to nutrition for the resident.

During an interview on 8/15/13 at 2:00 P.M. Dietary staff M reported I am assuming that it is me that is responsible to review weights. I go over them every week in care plan meetings. I take who I see has lost in the computer every Monday. Usually Direct care staff Q has all the weights in the computer by noon. If it is anything over about 5 pounds, wether it is a loss or a gain, I holler at them. We try to figure out what to do to solve the problem - nursing checks to see if medication is causing something, or if something

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with staff in the dining room. Consultant N comes in once a month and I tell him/her about any problems we have. We will call him/her if weight loss is identified, and Consultant N will come in or will talk over the phone. I believe the resident had a significant loss, but the resident had quit coming to the dining room, started to eat in his/her room, and began to not eat as much. The resident would take 2 or 3 bites, and then say he/she was sick. Dietary staff M identified the resident as a hoarder, when the snack tray comes around the resident would take 2-3 things off of it. I think staff offer the supplements, we have some that are not milk based, but I do not know if the resident would drink them. Staff do not really document the supplements. I think it is on everyone's orders there is a standing order for shakes. Staff are supposed to offer if a resident is not eating or had drastic weight loss. Staff M stated the resident has not had anything changed with his/her diet, he/she is offered just what is available. Staff probably did not document the supplements. I dont think he/she drank them so staff quit offering them. I know I did not document that.

On 8/15/13 at 3:49 P.M. Administrative Nurse A reported he/she was not aware of the resident having any weight loss. Staff A stated weight loss was discussed during care plans, the team talks about weight loss, do weights, what supplements had been given, but Staff A stated he/she was not aware that staff failed to document the supplements. When staff chart the meals, Staff A thought the staff charted the supplements, also. Staff A identified the staff were putting the supplements on the TAR (Treatment Administration Record), that way the charge nurse has to supervise and ensure the resident is getting them. And if the resident refuses, this

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needs to be charted. I do not know if there is a "designated person" for identifying weight loss. Once someone has been identified with a weight loss, staff should put the resident at the assisted feeding table, provide supplements, provide an appetite stimulator, and if that did not work, get them in for tests. Dietary staff M should be monitoring and bring the concerns to care plan, notify Consultant N and the doctor right away. Consultant N should see them and make recommendations.

Interview on 8/20/13 at 1:49 p.m. with Consultant N revealed he/she had not been notified of the resident's weight loss and expected to be notified as soon as staff identified weight loss. Staff N reported that he/she made monthly visits to the facility, reviewed a referral list from Dietary staff M, talked with staff M and administrative nursing staff A to identify issues, if needed discussed concerns with family members and health care providers, and occasionally attended care plan meetings. Staff N reported his/her definitions of significant weight loss were concurrent with the state regulations and if a resident had significant weight loss, depending on the resident's diagnosis and ability to eat, staff N would make recommendations for dietery supplements, increasing food intake, diet changes, and talk with the provider among other things to develop an individualized plan for the resident to prevent any further weight loss.

Review of the facility's undated policy for Interdepartmental Notifications of Diet (Including Changes and Reports) revealed, "Nursing services shall notify the physician and the clinical dietician when a nutritional problem (... weight loss, pressure ulcer, eating problems...) has been identified and shall collaborate with the dieticiain

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F 325	Continued From page 114 and physician to initiate an appropriated process of clinical review for causes of the nutritional problem." The facility failed to have a system that identified, developed, implemented and reviewed interventions when a resident started to lose weight to prevent a significant weight loss. The resident lost 6.14% of weight between 6/25 and 7/29, or 8.2 pounds.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This Requirement is not met as evidenced by:	F 329		

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The facility census totaled 25 residents with 18 residents included in the sample. The sample included the review of the medication regimens for 7 residents. Based on observation, interview and record review, the facility failed to attempt non-pharmacological interventions prior to the administration of PRN (as needed) psychoactive medications, failed to identify specific, targeted behaviors and document on those behaviors for residents on psychoactive medications, and failed to care plan the severe side effects of all medications for 2 of 7 sampled residents. (#31 and #34)

Findings included:

- Resident #31's signed physician orders, dated 8/7/13, revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion) in conditions classified elsewhere with behavioral disturbance.

The quarterly Minimum Data Set 3.0 assessment (MDS), dated 5/16/13, revealed the resident had a (BIMS) Brief Interview for Mental Status score of 9 which indicated a moderate cognitive impairment. The resident had delusions but did not display physical or verbal behavioral symptoms directed towards others, wandering, or rejection of care. The resident had other behavioral symptoms not directed towards others daily. The resident received diuretics, antidepressants, and antianxiety medications 7 of 7 days of the look-back period. the admission MDS, dated 11/13/12, revealed the resident a BIMS score of 3 indicating a severe cognitive impairment, and he/she did not experience hallucinations or delusions. The resident wandered daily, had no other behavioral symptoms and received an antidepressant and

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F 329	Continued From page 116 antianxiety medications 7 of 7 days of the look-back period. Review of the 11/13/12 Care Area Assessment (CAAs) summary revealed no analysis of findings for Cognitive Loss/Dementia, Psychotropic Drug Use or Behavioral Symptoms. The 5/21/13 revised care plan revealed the following interventions: For dementia: encourage family to visit often, approach in a calm and pleasant manor, introduce self to the resident, call the resident's name and gain his/her attention befor speaking, ensure quiet surroundings to reduce distraction, use simple and direct statements, repeat and rephrase as necessary, invite the resident to activities and exercise, ensure the resident's hearing aides were working properly, reorient as needed, be kind, and ensure the resident had glasses in place. For anxiety/depression: report changes to the nurse of increased symptoms of depression or anxiety or lethargy. For medicatons: report suicidal thinking, changes in behavior, giving away prized possessions, negative verbalizations, increased sedation or anxiety, do not give more than 4000 milligrams (mg) of Tylenol in 24 hours, do not withdrawal Metoprolol (cardiac medication) suddenly, report any complaints of stomach pain or bleeding. Further review of the current care plan revealed no target behaviors or individualized interventions to implement prior to administering as needed (PRN) psychoactive medications.	F 329		

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The 5/15/13 physician's progress note revealed the diagnoses of dementia with depression and dementia with behavioral disturbances. The physician indicated the staff did not report any problems with the resident and directed the staff to continue administering the resident's current medications.

The 8/7/13 hospital discharge orders signed by the physician revealed the following medication orders for the resident:

Bumex, 1 mg, ½ tablet orally, twice a day for heart failure (initiated on 1/17/13)
Haldol, (antipsychotic) 0.5 mg every 6 hours as needed for agitation (initiated on 8/1/13)
Haldol 0.5 mg, intramuscular every 6 hours as needed for agitation (initiated on 8/1/13)
Ativan (antianxiety) 0.5 mg, ½ tablet, three times a day as needed for anxiety or agitation (initiated on 1/17/13)
Metoprolol, (antihypertensive) 25 mg by mouth twice daily for hypertension (initiated on 1/15/13)

Review of the FDA (Food and Drug Administration) website for medications revealed the following Black Box Warnings (BBWs):

Bumex - electrolyte abnormalities, severe dehydration
Haldol - increased mortality in patients with dementia related psychosis
Metopropol - abrupt discontinuation may lead to increased cardiovascular events

The August, 2013 (MAR) Medication Administration Record revealed the staff had administered a PRN Ativan to the resident on 8/1/13 at 2:24 A.M. which had been ineffective,

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although further documentation revealed the medication had been effective at 7:30 A.M. On 8/3/13 at 4:45 P.M. the staff had administered a PRN Haldol and it had been ineffective but on 8/8/13 at 7:44 P.M., the staff had again administered the PRN Haldol and the medication was effective.

The 8/1/13 at 7:30 A.M. nurses note revealed the nurse had administered Ativan as ordered orally as needed for the complaint of anxiety as directed by the physician's orders. Further review of the nurses notes revealed no documentation of interventions staff had tried before administering the medication to the resident.

The 8/3/13 at 4:45 P.M. nurses notes revealed, the resident was screaming at the staff and not allowing the staff to assist him/her with (ADLs) activities of daily living. The documentation lacked any interventions were implemented by the staff prior to the administration of medication.

The 8/8/13 at 7:44 P.M. nurses notes revealed the staff administered, "1 tablet for agitation as ordered." The documentation lacked any interventions implemented by the staff prior to the administration of medication.

On 8/13/13 at 9:23 A.M. observation revealed the resident sat in a recliner in his/her room and when the resident attempted to stand up by him/herself a pull tab alarm activated and sounded. Further observation revealed multiple staff members responded in less than a minute to the sounding alarm and the resident spoke to the staff in sentences that did not make sense.

On 8/13/13 at 9:37 A.M. observation revealed the resident sat in a recliner in his/her room and

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when the resident attempted to get up by him/herself a pull tab alarm sounded. Multiple staff members responded in less than a minute and the resident spoke to the staff in sentences that did not make sense.

On 8/13/13 at 3:50 P.M. direct care staff H reported the resident displayed behaviors of confusion, wandering, screaming/yelling out and swatting at people. Direct care staff H reported the (CNAs) certified nurse aides could chart one behavior at a time in the computer and then they are to tell the nurse.

On 8/14/13 at 11:19 A.M. direct care staff J reported the staff monitor the resident for abnormal behaviors, such as agitation and then staff would offer something to eat or try to assist him/her with going to sleep. Direct care staff J reported it not abnormal for the resident to talk to himself/herself. and reported CNAs had a place on the computer to document bad behaviors. Direct care staff J verified he/she was not aware of what medications were that had a black bock warning.

On 8/14/13 at 9:20 A.M. licensed nurse K stated he/she expected the CNAs to report changes in residents' behavior, mental status, skin changes, and vital sign changes. Licensed nurse K stated he/she expected the CNAs to know what a BBW was in general and that they should report changes in the residents to the nurse. Licensed nurse K stated that if a resident received antianxiety, antidepressant, or antipsychotic medications that there isn't really a check-off system, but behaviors are to be charted in the narrative nurses notes and the CNAs chart some behaviors in the computer. Licensed nurse K stated there is not daily charting on behaviors but

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behaviors only get charted if there is a change. The licensed nurse verified the resident has dementia and does have delusions is suspicious and displays paranoia at times. The interventions for the resident's behaviors included bringing him/her out by the nurses station for reassurance, closer observation, 1 to 1 care and the offering of snacks were reported by licensed nurse K. Licensed nurse K verified the resident had received some PRN Haldol and Ativan, and Bumex and he/she should be monitored closely.

On 8/15/13 at 5:15 P,M. administrative nurse A reported he/she expected the staff to administer antipsychotic medications if the resident's behaviors were unmanageable through other means and expected staff to give the medication only as a last intervention. Administrative nurse A stated he/she expected the staff to document any interventions attempted prior to the administration of PRN medications. Administrative nurse A verified the CNAs not aware of BBWs, but the nurses know about them and the BBWs should be on the MAR and on the care plan.

Review of the facility's Unnecessary Drugs policy dated 2/1/06 revealed, "The facility will ensure that each resident's drug regime is free from unnecessary drugs." It also revealed, "Unnecessary Drug-an unnecessary drug is any drug when used; 1. In excessive dose (including duplicate therapy(s); poly co-pharmacy 2. For excessive duration 3. Without adequate monitoring 4. In the presence of adverse consequences which indicate the dose should be reduced or discontinued. 5. Any combination of the above reasons; or 6. Without an appropriate and/or substantiated prescription."

The facility failed to ensure Resident #31 was

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F 329	Continued From page 121 free from unnecessary medications when staff failed to have individualized non- pharmacological interventions which staff implemented prior to administering antipsychotic and antianxiety medications for targeted behaviors and failed to monitor the resident for potential effects of medications that have BBWs, - Resident #34's signed physician orders, dated 8/107/13, revealed a diagnosis of vascular dementia (progressive mental disorder characterized by failing memory, confusion). The admission (MDS) Minimum Data Set 3.0 assessment, dated 5/2/13, revealed a (BIMS) Brief Interview for Mental Status of 2, indicating a severe cognitive impairment and required setup help for transfers, was independent with setup help for toileting, and required supervision with setup help for walking in the room and corridor. the assessment revealed the resident had not had any falls. The quarterly MDS dated 8/2/13 revealed the resident had poor short and long term memory recall, continuously had inattention, disorganized thinking and had moderately impaired decision making skills. The assessment indicated the resident required extensive assistance of one person for transfers, walking in the room and corridor, dressing, eating, and toileting. The resident had one or more minor injury falls since the previous assessment, and one fall with major injury. The assessment indicated the resident had delusions, physicial, verbal and other behavioral symptoms directed towards others, and rejection of care 1-3 days, and wandering 4-6 days of the look-back period. The resident had received diuretic and antipsychotic medications and 7 of 7 days of the look-back period.	F 329		

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F 329	Continued From page 122 Review of the 5/7/13 (CAAs) Care Area Assessment summary revealed the following: Cognitive Loss/Dementia CAA revealed an analysis of findings of, "Resident very confused and has more difficulty during late afternoon and evening." Review of the Falls CAA revealed an analysis of findings of "Resident wanders throughout the facility with and without walker or cane. Fall potential is high due to unsteadiness." Review of the Behavioral Symptoms CAA an analysis of findings of, "Resident gets very aggressive and agitated in late afternoon and evening." Review of the Psychotropic Drug Use CAA an analysis of findings of, "Resident takes psychotropic medication." The 5/21/13 revised care plan revealed the following interventions: reduce any distractions (turn off TV, radio, close door), use consistent, simple, directive sentences, provide the resident with necessary cues, stop and return if agitated, engage the resident in simple, structured activities that avoid overly demanding tasks, keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion, monitor/document/report to the physician any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, or mental status. For elopement risk: distract the resident from wandering by offering pleasant diversions,	F 329		

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F 329	Continued From page 123 structured activities, food, conversation, television, or a book (the resident prefers: talking one on one), monitor for fatigue and weight loss, provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. "WANDER ALERT " :Check and ensure placement of wander guard alarm on right wrist every shift." For potential for physical behaviors towards others, (last revised 6/6/13): directed staff to assess and anticipate the resident's needs (food, thirst. toileting needs, comfort level, body positioning, pain), provide physical and verbal cues to alleviate anxiety, give positive feedback, assist the resident to verbalize the source of agitation, assist the resident to set goals for more pleasant behavior, encourage seeking out of staff member when agitated, monitor/document/report to the physician any danger to self and others, psychiatric/psych-ogeriatric consult as indicated, intervene when the resident becomes agitated before agitation escalates, guide the resident away from the source of distress, engage calmly in conversation and if the resident's response is aggressive, staff should walk calmly away, and approach later. For sexually inappropriate behaviors,(last revised on 6/6/2013): discuss the resident's behavior, explain/reinforce why the behavior was inappropriate and/or unacceptable, minimize the potential for the resident's disruptive behaviors of sexually inappropriate statements by offering conversation which divert attention from behavior of focus.	F 329		

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F 329	Continued From page 124 The 8/10/13 hospital discharge instructions signed by the physician revealed the following medication orders for the resident: Bumex (diuretic) 0.5 (mg) milligrams twice a day for orthostatic hypotension (initiated on 6/20/13) Tylenol, 325 mg, two tablets, every 4 hours (PRN) as needed for pain (initiated on 6/20/13) Lortab 5/500 every 4 hours for pain (initiated on 6/21/13) Aspirin 81 mg daily for cardiac protection (initiated on 4/25/13) Potassium chloride, 20 meq (milliequvillants) daily for supplement (initiated on 6/7/13) Seroquel (antipsychotic) 25 mg every bedtime for vascular dementia (initiated on 4/25/13) with a dose reduction on 7/4/13 Observation on 8/13/13 at 2:55 P.M. revealed the resident interacted appropriately with laundry staff as staff put away the resident's clothes. Observation on 8/14/13 at 11:06 A.M. revealed the resident interacted appropriately with nursing staff. On 8/13/13 at 3:50 P.M. direct care staff H revealed he/she did not really know what a black box warning for a medication was. Direct care staff H stated he/she would ask the nurse if any medication required special monitoring. On 8/14/13 at 11:19 A.M. direct care staff J stated he/she did not know of any medications the resident took that needed special monitoring for side effects. On 8/14/13 at 3:31 P.M. licensed nurse K stated the resident took Seroquel, so he/she needed to be monitored for behaviors. Licensed nurse K	F 329		

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F 329	Continued From page 125 stated the behaviors get charted in a behavior note by the nurse, and the CNAs can chart some behaviors in the computer also. The resident also takes a diuretic and blood pressure medication that require monitoring by the nurse. On 8/15/13 at 5:15 P.M. administrative nurse A stated the purpose of the CAA is to assess that area of care and look at the different problems that cause the area to trigger and you have to look at the total person in each area of care and see what problems are in that area and then develop the care plan to try to improve or maintain those areas. Administrative nurse A verified the facility ' s behavioral monitoring system needs work. Review of the facility's Unnecessary Drugs policy dated 2/1/06 revealed, "The facility will ensure that each resident's drug regime is free from unnecessary drugs." It also revealed, "Unnecessary Drug-an unnecessary drug is any drug when used; 1. In excessive dose (including duplicate therapy(s); poly co-pharmacy 2. For excessive duration 3. Without adequate monitoring 4. In the presence of adverse consequences which indicate the dose should be reduced or discontinued. 5. Any combination of the above reasons; or 6. Without an appropriate and/or substantiated prescription." The facility failed to ensure Resident #31 was free from unnecessary medications when staff failed to have individualized non-pharmacological interventions which staff implemented prior to administering antipsychotic and antianxiety medications for targeted behaviors and failed to monitor the resident for potential effects of medications that have BBWs.	F 329		
F 353	483.30(a) SUFFICIENT 24-HR NURSING STAFF	F 353		

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F 353 SS=F	Continued From page 126 PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This Requirement is not met as evidenced by: The facility census totaled 25 residents. Based on observation, interview, record review, and deficient practices cited during the survey, the facility failed to have sufficient staff to provide the necessary care and services or to provide supervision to ensure staff assisted the residents in a timely manner, and prevented weight loss, the development of pressure ulcers, and monitoring of skin issues such as bruising and skin tears. This had the potential to affect all the residents. Findings included:	F 353		

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F 353	Continued From page 127 - During interviews on 8/8/13 and 8/12/13 with 12 of the facility's residents, 5 identified the facility failed to have sufficient staffing. Interview with direct care staff E on 8/12/13 at 2:25 p.m. revealed he/she thought that usually there were enough staff to take care of the residents, but sometimes when some of the residents had a lot of behaviors, then he/she didn't feel like there were enough staff. Observation on 8/12/13 revealed a bathroom call light (emergency light) rang from 1:45 p.m.-1:48 p.m. . On 8/14/13, observation revealed a bedroom call light rang from from 8:46 a.m.- 9:03 a.m. (17 minutes) before a staff member entered the room to answer the call light. On 8/14/13, a bedroom call light rang from 12:06 p.m.- 12:11 p.m. (5 minutes) before staff answered the light. On 8/14/13 observation revealed a personal alarm on a resident at risk for falls went off from 1:51 p.m. While the alarm sounded, observation revealed the resident made multiple attempts to get up and walk on his/her own. Nursing staff answered the alarm on 1:53 p.m. Interview on 8/14/13 at 11:38 p.m. with direct care staff J revealed he/she felt it varied from day to day and if one particular resident needed a lot of one-on-one attention that day, and if the resident did, then staff J reported that he/she did not feel like there were enough staff available for him/her to take care of the other residents well. Staff J reported that usually, the people from the offices were really good about stepping in to help.	F 353		

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F 353	Continued From page 128 Review of the resident council meeting minutes for 2013 revealed the residents raised concerns with staffing issues in January, (no meeting in February), March, May, and July. During an interview with a resident who frequently attended resident council at 3:26 p.m. on 8/13/13, he/she confirmed residents had concerns with staffing, and call lights being left on for long periods of time before staff could answer them. The resident confirmed the resident council had multiple repeated concerns. The facility failed to have sufficient staff to ensure the call lights and alarms were responded to in a timely manner. - During the survey, deficient practices were identified in the following areas: * The facility failed to document the administration of dietary supplements to residents with weight loss. See F325 for further information. * The facility failed to monitor the healing process for residents with bruises and skin tears. See F309 for further information. * The facility failed to monitor the direct care staff to ensure that residents with a history of pressure ulcers received the necessary turning and repositioning programs to ensure new pressure ulcers did not develop. See F314 for more information. The facility failed to have sufficient staff that provided the necessary oversight to ensure the direct care staff provided the planned	F 353		

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F 353	Continued From page 129 interventions to prevent deficient practices in the development of pressure ulcers, healing of bruises and skin tears, and weight loss.	F 353		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: The facility had one kitchen that served all the residents in the facility. Based on observations, interviews and record review the facility failed to store and serve food in a sanitary manner. This had the potential to affect all the residents in the facility. Findings included: - Observations during the Kitchen tour on 8/8/13 that started at 8:10 a.m. revealed the following. Dietary staff M, dietary supervisor reported the house shakes come in frozen, when the fridge gets low on shakes, they bring more in from freezer. Staff M reported there is no way to know if the shakes are outdated and reported he/she doesn't know when they expire. He/she stated he/she just opened them up and if they were nasty, they would replace all of them. There were 76 shakes in the refrigerator at this time.	F 371		

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F 371	Continued From page 130 At 8:25 a.m. on 8/8/13, observations revealed Pace picante sauce on the shelf in the food storage building, opened, dated 7/31/13, Dietary staff M reported it should have been in the kitchen and not out here so he/she was throwing it away. Observations of the outside storage unit on 8/8/13 at 9:00 AM revealed water on the floor of the outside storage building. Dry goods (sugar, flour, pasta) stored in outside storage building. Dietary Staff M reported there was no monitoring of the temperature in the outside storage building. There was a window air conditioning unit/heating unit that was set on 70 degrees and there was no thermometer in the building to monitor the temperature. There were two bags of open pasta with no date on the bags, in the outside storage unit. Staff M reported he/she was throwing them out since there was no expiration date on them. Interview at 9:15 a.m. with Dietary staff V on 8/8/13, reported when washing dishes, he/she washed the dishes in the sink with sanitizer first, did not know how much he/ she used then she/he takes them to the dish washing machine and runs them through the machine. Interview at 9:20 a.m. with Dietary staff W on 8/8/13, revealed he/she did not know if the machine was a high temperature or low temperature machine. She/he takes the temperature in the water outside the machine. She/he also said that sometimes if the water sits too long, it gets cold, so she/he has to run the machine first to warm it up and then run the dishes through it. Observations at that time revealed that the maximum temperature the dish washer got up to was 156.0 degrees F.	F 371		

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F 371	Continued From page 131 Review of the facility ' s policy on " Sanitary Conditions " dated 12/6/12: " Food preparation equipment, dishes, utensils are effectively sanitized to destroy potential disease-carrying organisms. Proper dishwashing procedures will be followed. " The facility failed to store and serve food in a sanitary manner.	F 371		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This Requirement is not met as evidenced by: The facility census totaled 25 with 18 resident's included in the sample. Based on observation, interview, and record review, the facility failed to provide routine dental services for 2 of 3 sampled residents by the failure to address resident #23's chipped left front tooth, and failed to ensure a resident (#25) received a follow-up appointment to address a broken tooth. Findings included:	F 411		

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F 411	Continued From page 132 - Review of resident # 23's significant change MDS (minimum data set) dated 10/24/12 identified the resident had a BIMS (brief interview for mental status) with a score of 00 (severe impairment). It identified the resident had rejection of care behaviors for 4 to 6 days. It identified the resident needed extensive assistance of one person for bed mobility, transferring, dressing, and toilet use and the resident needed limited assistance of one person for eating and personal hygiene. It identified the resident had no obvious or likely cavity or broken natural teeth and no mouth or facial pain, discomfort or difficulty with chewing. Review of the resident's quarterly MDS dated 7/12/13 revealed a BIMS with a score of 99 (unable to complete the interview). It identified the resident had short and long term memory problems. It also identified the resident had no rejection of care behaviors exhibited. It identified the resident needed limited assistance of one person for bed mobility, needed supervision of one person for transferring, and extensive assistance of one person for dressing, eating, toilet use, and personal hygiene. It also identified the resident had no mouth or facial pain, discomfort, or difficulty with chewing. Review of the Cognitive Loss/Dementia CAA (care area assessment) dated 10/24/12 revealed no analysis of findings documented. The Dental Care CAA did not trigger for this resident. Review of the care plan with a date of 5/1/13 revealed the resident had a self care deficit related to progressive dementia (a progressive mental disorder characterized by failing memory and/or confusion). It identified the resident required limited assistance with brushing teeth	F 411		

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F 411	Continued From page 133 every morning and every night and directed the staff to set up his/her moistened toothbrush with toothpaste and guide his/her hand if he/she will allow and if not, staff are to attempt to brush his/her teeth. The care plan lacked any information regarding the resident's chipped left front tooth. Review of the resident's "oral interview" regarding her oral status, asked if the resident had any obvious or likely cavity or broken natural teeth and the answer filled in is "no". Review of a fax provided to the facility by the resident's dentist office dated 12/20/12, revealed the resident's chipped tooth was not addressed in the dental visit. Review of the resident's chart revealed no documentation recorded that the resident's family was notified of the resident's broken tooth. The facility failed to provide any documentation regarding the resident' chipped front tooth, or any documentation that the resident's family was notified. On 8/12/13 at 2:40 p.m. observation of the resident revealed the resident sitting in the entryway talking with staff. The resident's front tooth (left) is chipped. On 8/13/13 at 1:11 p.m. an interview with direct care staff E revealed he/she would report to the nurse if a resident's gums were bleeding, had sore dentures, their dentures didn't fit correctly, or if the resident had chipped teeth. Staff E reported he/she didn't know if the resident had any problems with his/her teeth and reported he/she did not know the resident had a chipped tooth.	F 411		

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F 411	Continued From page 134 On 8/13/13 at 1:15 p.m. an interview with direct care staff C revealed he/she would let the nurse know about blisters on a resident's gums, bleeding gums, discoloration, loose teeth, broken dentures, chipped or broken teeth. Staff C stated he/she did not think the resident had any problems with his/her teeth and did not notice he/she had a chipped front tooth. On 8/13/13 at 1:45 p.m. an interview with administrative staff B revealed he/she fills out an "oral interview" form for the residents. Staff B reported another staff member looks in the resident's mouths, fills out some other form, gives it to staff B and staff B then is able to fill out the "oral interview" form from that information. On 8/13/13 at 1:55 p.m. an interview with licensed staff L, revealed he/she would expect the CNA's to report bleeding gums, foul smelling mouth, discoloration of gums, chipped teeth, missing teeth, dentures that did not fit correctly, if a resident was not eating because of their dentures not fitting correctly, and discoloration of natural teeth. Staff L reported after the aides notified her, he/she looked at the resident's teeth and would then call the resident's dentist. Staff L confirmed at that time, by looking in the resident's mouth, the resident had a chip in his/her left front tooth. Staff L confirmed the chip would be something he/she would have called the dentist about and he/she also confirmed he/she had not called the dentist about the chip in the resident's left front tooth. On 8/14/13 at 10:39 a.m. an interview with administrative staff A reported his/her expectation is for the nurse aides to report any dental issues to the charge nurses, the charge nurses are to document the issues in the nurses notes and the	F 411		

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charge nurses are to call the dentist and make an appointment or arrangements for the issues to be addressed. Staff A also confirmed any dental issues should be documented on the MDS. Staff A confirmed the aides should report to the charge nurse, any chipped teeth a resident had.

Review of the facility policy for Dental Services, with a date of 2/1/05, revealed "Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care".

The facility failed to address or provide routine dental care to address resident # 23's chipped left front tooth.

- Review of #25 Annual MDS (Minimum Data Set) assessment dated 6/13/13 revealed it identified the resident with a BIMS (Brief Interview for Mental Status) score of 11 (moderately impaired). The assessment identified the resident found it very important to have family or close friend involved in discussions about care. The MDS also identified the resident needed limited assistance of one staff member for personal hygiene, and had an obvious or likely cavity or broken natural teeth.

Review of the resident ' s Dental CAA (Care Area Assessment) for 6/13/13 MDS revealed the resident frequently complained of a bad tooth but had been addressed with the resident ' s family. It identified staff planned to focus the resident ' s care plan on prevention of further problems.

Review of the resident's care plan with an initiated date of 6/18/13 and next review date of 9/19/13 revealed it identified the resident had an oral/dental health problem of a hole in his/her

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tooth related to age and directed staff to coordinate arrangements for dental care, transportation as needed/as ordered, and the resident had his/her own teeth. It also identified the resident required 1 staff participation with personal hygiene and oral care.

Review of a noted dated 8/5/13 at 11:35 A.M. revealed it identified the resident had an appointment made to see a local dentist at 3:30 P.M. It identified the resident had a broken tooth that needed to be fixed. The identified staff notified family of this

Review of another note dated 8/5/13 4:30 P.M. revealed the resident returned from the dentist and needed to see a different dentist than noted above, when the dentist returned from vacation. The note identified they notified family of this.

During an interview with the resident at 10:00 A.M. on 8/15/13, the resident reported he/she did have a tooth broken. Observation at that time revealed the resident pointed to the right side of his/her mouth. The resident reported he/she thought it happened in his/her sleep, and the area made it hard for him/her to chew. The resident confirmed he/she did go to an appointment about it, but did not remember the plan, or if there was a plan to fix it. The resident confirmed he/she did want it fixed if possible.

At 3:07 P.M. on 8/14/13, Direct Care staff G reported he/she would tell the nurse if the resident complained about his/her teeth. Staff G reported the resident had not complained to him/her and did not know about any concerns related to the resident ' s teeth.

During an interview with Direct Care staff Q at

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11:01 A.M. on 8/14/13, staff Q reported he/she took the resident to the dentist the last week or the week before, and reported he/she remembered the resident had a broken off tooth. Staff Q reported he/she thought they had to temporarily file it down, but didn ' t know what anyone planned to do about it next or if the resident needed to go back.

At 12:05 P.M. on 8/15/13 Administrative Nursing staff A reported he/she reviewed the chart and did not see any information about follow-up related to the resident ' s teeth. At 12:28 P.M. that same day, Staff A reported he/she called and found out the resident had seen a dentist a couple weeks ago, and reported the resident did need to have work done and would see the dentist when the dentist came back from vacation. Staff A reported the resident did not have an appointment made and would call and make one. When asked when/how that appointment should have gotten made, staff A reported the nursing staff member who wrote the note should have called and addressed it. At 3:49 P.M. that same day, Staff A reported he/she called to make the appointment and found out he/she needed approval from the family prior to making the appointment. Staff A reported he/she thought that might have been why staff did not get the appointment made. Staff A confirmed he/she called the family and they did want the tooth issue addressed so Staff A made the appointment. Staff A confirmed he/she expected the nursing staff who received the information from the appointments to set up any recommended follow-ups.

Review of the facility ' s policy for Dental services dated 2/1/05 revealed " Routine and emergency dental service are available to meet the resident '

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F 411	Continued From page 138 s oral health services in accordance with the resident ' s assessment and plan of care. " The facility failed to ensure a resident received a follow-up appointment for addressing a broken tooth.	F 411		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		

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This Requirement is not met as evidenced by:
The facility census totaled 25 residents and reported 13 residents had the potential to receive PRN (as needed) narcotic pain medication or benzodiazepines (psychoactive medications). Based on observation, interview and record review, the facility failed to ensure the accurate dispensing of as needed controlled PRN medications. This had the potential to affect all 13 residents who had orders for PRN narcotic or benzodiazepine medications.

Findings included:

- Observation at 4:23 P.M. on 8/13/13 revealed Direct Care staff T pushed the cart up to a resident's room and reported he/she planned to give the resident a pain pill. "The nurse told me [gender] needed a pain pill." Observation revealed Direct Care staff T popped the medication out of the card and signed the narcotic count sheet in the notebook. Staff T reported he/she signed on the narcotic count sheet and gave the medication, but did not document it on the MAR (Medication Administration Record). Staff T reported the nurse did the documentation for giving the pill on the MAR. Observation at that time revealed Direct Care staff T provided the resident with a Lortab 5/325 (narcotic pain medication).

Review of the narcotic Count Sheet (kept track of how many pills resided in each card and who popped out the pill to give it to a resident) with an initial count of 30 pills on 7/12/13 revealed it identified staff signed out the medication 1 time in August, 2013 and the Count Sheet with an initial

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count of 30 pills of 7/29/13 revealed it identified staff signed out the medication 10 times in August, 2013, a total of 11 times staff signed out the medication in August to give it to the resident. Review of the MAR for August, 2013 revealed it only identified the resident received the medication 7 times.

Review of the narcotic Count Sheet with an initial count of 30 pills on 7/29/13 revealed it identified staff signed out the medication 1 time in July, 2013, and the Count Sheet with an initial count of 30 pills on 7/12/13 revealed it identified the resident received the medication 30 times in July, 2013, a total of 31 times. Review of the July, 2013 MAR revealed documentation the resident only received the medication 19 times. Review also revealed multiple days in July and August 2013, where one staff member signed the medication out on the narcotic Count Sheet record, but the MAR identified a different person initialed the medication as given.

During an interview at 12:30 P.M. on 8/14/13, Licensed Nursing staff K reported the nurse assessed a resident if the resident complained of pain, then if the resident needed pain medication, the medication aide gave the medication and signed it out on the narcotic Count Sheet. The nurse then signed off on the MAR that the resident received the medication. Staff K confirmed he/she signed that the resident received the medication, even though the medication aide gave it to the resident. At 6:10 P.M. on 8/26/13, Staff K confirmed staff used this same system for PRN benzodiazepines as well.

At 4:30 P.M. on 8/15/13, Administrative Nursing staff A reported he/she expected a staff member to sign only when he or she actually administered

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F 431	Continued From page 141 the medication to the resident. Staff A confirmed the facility did not have a policy for this, and planned to write one. Review of the facility's Medication Administration policy dated 2/1/05 revealed, "...4. All medication administered shall be immediately and appropriately documented on themedication administration record by the employee giving the medication." The facility failed to ensure the accurate dispensing of controlled PRN narcotic and benzodiazepine medications.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441		

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F 441	Continued From page 142 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This Requirement is not met as evidenced by: The facility census totaled 25 residents. Based on observation, interview and record review, the facility failed to have systems in place to maintain an infection control program for identifying or preventing the spread of infection, and failed to have sufficient sanitizing chemicals available for cleaning rooms of residents admitted with Clostridium difficile (C-diff- a contagious bacteria characterized by foul smelling frequent bowel movements). The lack of an effective infection control program had the potential to affect the 25 residents who reside in the facility. Findings included: - On 8/14/13 at during environmental tour which started at 4:15 P.M. observation revealed an assistive walking device, used by restorative staff, which had a foam handle wrapped with dirty/discolored gauze like dressing material. Review of the facility's cleaning materials revealed the facility had 14 Antibacterial "All Purpose Cleaners. Review of the label	F 441		

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information for the ECOLAB cleaners revealed no information regarding whether the chemical killed the C-diff bacteria. Review of the Product Specification document for 66 Heavy Duty Alkaline Bathroom Cleaner and Disinfectant by ECOLAB lacked any indication it killed C-diff bacteria.

Review of the facility's laundry chemicals revealed the facility used Eco Start L-2000 XP Laundry Detergent by ECOLAB. Review of the Product Specification Document revealed it lacked any indication it killed C-diff. bacteria.

On 8/14/13 at 1158 A.M., housekeeping staff R stated when cleaning an isolation area the staff to wear gloves, gowns, sometimes have to wear mask. Housekeeping staff R reported that all of the facility's all-purpose chemicals kill everything including bacteria from C-diff. When asked about chemical contact times or special instructions for the chemicals, housekeeping staff R stated he/she was unaware of how long the contact time would be but he/she would spray it and then go back and wipe it off. Housekeeping staff R did not identify any time frame for the contact of the chemicals.

On 8/14/13 at 4:45 P.M. Housekeeping supervisory staff S stated the staff clean with all-purpose disinfectants and would clean any isolation rooms with the same all-purpose chemicals. Housekeeping administrative staff S stated the fixtures and sinks in isolation rooms would be cleaned at least twice a day if not more but the staff would use the same all-purpose chemical. Housekeeping administrative staff S verified there is no specific contact times for the

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chemicals that he/she is aware of. Housekeeping supervisory staff S stated the facility used ECOLAB L2000 detergent for laundry using bleach for hand towels, and sheets, however personal laundry is just done with L2000.

On 8/14/13 at 5:50 P.M., Dietary staff M reported the facility did have chemical for cleaning when a resident was diagnosed with C-diff but he/she was uncertain as to what the chemical was or where it was stored.

On 8/15/13 at 1:38 P.M. housekeeping supervisory staff s stated the facility relied on detergent for sanitizing and not on hot water for the sanitization.

Review of Inactivation of and article, " Clostridium difficile, " <http://www.cdc.gov/hai/organisms/cdiff/cdiff_faqs_hcp.html>, revealed, ... " Because C. difficile spor-production can increase when exposed to nonchlorine-based cleaning agents and the spores are more resistant than the vegetative cells to commonly used surface disinfectants, some investigators have recommended use of dilute solutions of hypochlorite (1600 pp, (parts per million) available chlorine) for routine environmental disinfection o rooms of patients with C.difficile-associated diarrhea or colitis, to reduce the incidence of C/ difficile diarrhea, or in units with high C. difficile rates. "

Review of the facility ' s Infection Control: Admission policy dated 5/1/05 revealed, " Admission dependent upon the facility ' s ability to provide appropriate medical and nursing care. The facility ' s ability to provide adequate care is

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the predominant criteria in admitting, or not admitting, a resident with a known communicable disease or infection. " It also noted, " ...3. [Facility[will accept persons isolated for infections only as it is capable of providing care for those persons needing isolation barriers. "

The facility failed to have adequate housekeeping and laundry disinfectants available for cleaning of an environment and laundry items contaminated by C-diff bacteria to ensure adequate infection control practices for the 25 residents who reside in the facility.

- Observation at 2:09 P.M. on 8/13/13 revealed Direct Care staff T pushed Tylenol and Gabapentin (a medication used to relieve nerve pain in the extremities) (2 pills total) from medication cards out into a cup for the resident to consume. The resident then reported he/she wanted to pills crushed. Staff T walked back to the cart, and touched the pill attempting to pick it up. Staff T put the Tylenol into a little sleeve to crush it, and picked up the Gabapentin (a capsule). With bare hands, staff T twisted the Gabapentin and poured the granules from inside into a cup, poured in the now crushed Tylenol with it, added applesauce to the cup of medication and provided it to the resident to consume.

Review of the facility's infection control documentation revealed no current system in place to identify specific organisms, treatments, follow-up after treatment or any format to effectively identify trends within the facility in a timely manner.

On 8/15/13 at 1:10 P.M. Nurse B stated he/she was responsible for the facility's infection control

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program and currently at the end of each month he/she went through medical records to determine if a resident has had an infection. Nurse B verified there is not current an effective system in place for documentation including the identification of trends related to infections in the facility and the last documentation of infection control issues in the facility was dated May 30, 2013. Nurse B indicated he/she had an interdisciplinary meeting which included discussion of infection control issues in June 2013. Nurse B verified the most recent infection control meeting was June 20, 2013 and the previous meeting was held on March 27, 2013. Nurse B stated the staff should punch pills from the medication cards directly in to medication cups and should not touch the residents ' pills. Even the capsules or medications being crushed should not be handled by staff unless he/she is wearing gloves.

On 8/15/13 at 4:30 P.M. administrative nurse A verified staff should not touch the residents' pills with their bare hands.

Review of the facility ' s Disease Specific Information-Surveillance for Nosocomial Infections policy dated 4/1/05 revealed it identified, ... " 3. The charge nurse should perform routine surveillance for nosocomial infections within the facility. Infection control personnel should use case-finding methods that are appropriate for the available resource and characteristics of the facility 4. Perform the surveillance using any or all of the following data gathering tools as possible indicators of nosocomial infections : a. Laboratory records; b. Skin care sheets c. Infection control rounds or interviews; d. Infection surveillance sheets; e. temperature logs f. Pharmacy records (e.g.,

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F 441	Continued From page 147 residents on antibiotics) ; and g. Transfer log/summaries. 5. If a trend or outbreak is evident by the infection control log the charge nurse or Director of Nursing will a. Investigate to see if the breakouts are in a particular area in the building or being cared for by the same staff b. Attempt to isolate the host whether it be an employee or a food or other vector. C. Provide education to the group of individuals as needed d. Report as needed to Health Department and/or physician. The facility failed to ensure an effective infection control program is developed and maintained which includes monitoring appropriate disinfection of multi-resident medical equipment and trends to identify staff education needs such as appropriate hand washing.	F 441		
F 469 SS=F	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This Requirement is not met as evidenced by: The facility census totaled 25 residents. Based on observation, interview and record review, the facility failed to have an effective pest control program so that the facility is free of pests and rodents by the failure to eradicate and contain flies. This had the potential to affect the 9 residents who had flies on their person or in their room in the facility. Findings included: - Observation on 8/8/13 at 3:09 P.M. in a room down the north hall revealed the resident asleep.	F 469		

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Observation at that time revealed flies on the resident ' s nose, mouth and arms while the resident slept.

Observation on 8/8/13 and 8/12/13 revealed 7 more resident rooms with flies in them flying around or around the residents.

Observation on 8/13/13 at 9:10 a.m., observation in a resident ' s room down the north hall (one of the residents observed with flies on 8/8/13) revealed a fly inside the resident ' s soda pop bottle. Observation revealed the resident drank from the bottle prior to noticing the bottle held the fly inside of it.

Observation at 11:23 A.M. on 8/13/13 revealed another resident in a room down the south hall sat in a recliner and continually readjusted a blanket in his/her lap. Two flies flew around the resident and landed on the resident ' s legs. The resident then took a laminated sheet of paper and hit at his/her bare leg multiple times, then scratched it with his/her fingernails where the resident had been crawling.

At 4:30 P.M. on 8/13/13, Direct Care staff T reported the flies " are eating us up" and confirmed they bothered the residents.

During environmental tour which started at 4:15 P.M. on 8/14/13, interview with Maintenance staff U revealed he/she called the pest control company to come and treat this last Sunday. Staff U reported the company treated multiple areas, and instructed Staff U to get bait stations to pull the flies away from the building. Staff U reported he/she thought the front door stayed open too long and that may have been how the flies got in.

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F 469	Continued From page 149 During an interview at 4:30 P.M. on 8/15/13 Administrative Nursing staff A confirmed the facility had had a problem with the flies for a few weeks now. Review of the facility ' s undated Pest Control Policy revealed, " [Facility] contracts with [company name], they provide monthly inspections and emergency calls if pests are found in or around the facility. The Environmental Manager oversees the labor provided by [company name] and works with them to provide a pest free Environment. " The facility failed to maintain an effective pest control program to eradicate and contain flies.	F 469		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520		

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F 520	Continued From page 150 Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This Requirement is not met as evidenced by: The facility census totaled 25 residents. Based upon deficient practices identified during the survey and interview, the facility failed to have a QAA (Quality Assessment and Assurance) that identified and developed and implemented appropriate plans of action to correct quality deficiencies. This had the potential to affect all the residents. Findings included: - The facility failed to identify and provide interventions for severe weight loss in 2 of 4 residents reviewed for nutrition (#34, #8). Resident #34 lost 39.4 pounds from 6/4/13 until 7/29/13, or 18% of his/her weight. Resident #8 lost 8.2 pounds from 6/25/13 until 7/29/13, for a 6.1% weight loss. See F325 for more information. - The facility failed to have systems in place to maintain an infection control program for identifying or preventing the spread of infection, and failed to have sufficient sanitizing chemicals available for cleaning rooms of residents admitted with Clostridium difficile (C-diff- a contagious bacteria characterized by foul smelling frequent bowel movements). The lack of an effective infection control program had the potential to affect the 25 residents who reside in the facility. See F441 for more information. - The facility failed to thoroughly investigate all falls and implement appropriate fall interventions to prevent accidents for 2 of 4 residents (#34,	F 520		

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#26), resulting in an injury for resident #34. The facility also failed to prevent accidents due to unsecured chemical storage for 6 cognitively impaired, independently mobile residents. See F323 for more information.

- The facility failed to ensure 1 of 3 sampled residents could make choices about his/her bathing schedule. (#25) See F242 for more information.

- The facility failed to provide routine dental services, by failing to address resident #23's chipped left front tooth and failing to address resident #25's broken tooth that has been sore, for 2 of 3 resident's sampled. See F411 for more information.

- The facility failed to provide routine monitoring of bruises and skin tears to ensure the skin issues healed without complications and failed to develop interventions to prevent additional occurrences of bruising and skin tears for 3 of the 3 residents sampled for skin issues. (#25, #26 and #31). See F309 for more information.

- The facility failed to prevent the re-opening and worsening of multiple stage II pressure ulcers for 1 of 2 residents reviewed for pressure ulcers. The resident had pressure ulcers that developed, closed, and then redeveloped from 3/2013 through from 6/2013. (#10). See F314 for more information.

- The facility failed to have an effective pest control program so that the facility is free of pests and rodents by the failure to eradicate and contain flies. This had the potential to affect the 9 residents who had flies on their person or in their room in the facility. See F469 for more

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F 520	Continued From page 152 information. - The facility failed to ensure the accurate dispensing of as needed (PRN) controlled medications. This had the potential to affect all 13 residents who had orders for PRN narcotic or benzodiazepine medications. See F431 for more information. - The facility failed to ensure alleged allegations of abuse involving mistreatment of a resident by another resident, were investigated, for 1 of 3 sampled residents. (#13). See F225 for more information. - The facility failed to have a system to ensure the accurate completion of the CAAs (Care Area Assessments) for care areas identified on the MDS (Minimum Data Set) that required a further assessment) for 9 of the 18 sampled residents with comprehensive assessments. (#30, #11, #31, #1, #34, #8, #25, #27, and #26). See F272 for more information. - The facility failed to plan the care of 4 of 18 sampled residents in regard to nutrition, skin conditions not pressure related, urinary incontinence, and ADL (Activities of Daily Living) needs for dental hygiene. (#26, #34, #8, #33) See F279 for more information. - The facility failed to follow the incontinence program and maintain, prevent decline, or improve urinary continence for 2 of 4 sampled residents reviewed for urinary incontinence (#34 and #13). Resident #34's urinary continence declined over a 3 1/2 month period. See F315 for more information. - The facility failed to provide a private space for	F 520		

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the resident council to meet, and failed to ensure staff received an invitation from the resident council group prior to staff attending. This had the potential to affect all residents who attended the resident council meetings. See F244 for more information.

- The facility failed to store and serve food in a sanitary manner. This had the potential to affect all the residents in the facility.

On 8/15/13 at 5:15 p.m., Administrative Nurse A identified they were in charge of the facility's QAA program for the last 2 months. Nurse A confirmed the facility's QAA program had not identified issues with several quality deficiencies found during the survey. For others, such as accidents, the facility planned to revise the manner in which the facility developed interventions because more training was needed with the staff.

Review of the facility's undated Continuous Quality Improvement (CQI) policy revealed the following:
"Because (facility) will strive to continually improve we will conduct CQI meetings at least quarterly. Weekly informal 'huddles' will be conducted with department heads and others available to work on continuing problem solving will be on Tuesdays at 1:30 unless otherwise stated.

Meeting Conduction:
Every department head will come prepared with a list of problems, an action plan and evaluation filled out. Each department head will share this with the group and the group will hold each department head accountable and are free to ask

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F 520	Continued From page 154 questions and give insight to better address every issue. Attendees that are not department heads are expected to give input and all are expected to work together as a team for the continuous improvement of (the facility). Items to be addressed include but are not limited to: Safety Any resident complaints or issues ie (falls, safety, skin, abuse/neglect, complaints, concerns, medication errors, etc...) Regulations QM, QIs (Quality Measures, Quality Improvement)" The facility failed to have an effective QAA program that identified quality deficiencies and developed and implemented plans to correct the deficient practice.	F 520		